

# HARVARD MEDICAL

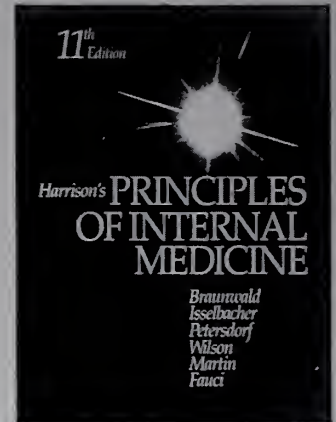
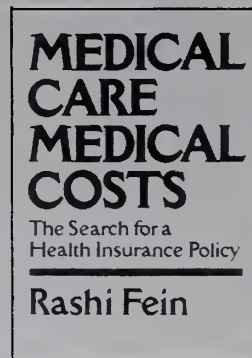
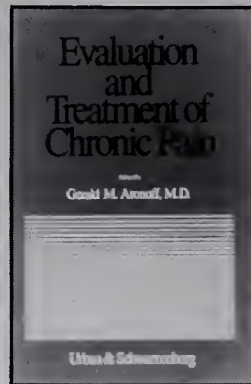
ALUMNI BULLETIN

SPRING 1987



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# HARVARD MEDICAL

ALUMNI BULLETIN / SPRING 1987 / VOL. 61 NO. 1

## DEPARTMENTS

- 16 **Expert Testimony: Doctors in Court**  
16 **The Adversarial Game: Step by Step Strategy for the Expert**  
*by Thomas Gutheil*  
18 **Speaking From Experience: Interview with a Litigation Lawyer**  
*by Debra J. Trione and Frank Reardon*  
22 **George Packer Berry 1898-1986**  
24 **Devoted to Science** *by Harold Amos*  
26 **Friend and Mentor** *by Charlotte Litt*  
28 **A Princeton Salute** *by Robert F. Goheen*  
30 **Dean With a Difference** *by George Thorn*  
32 **Powerful Ally** *by Roy O. Greep*  
33 **Humanist Convictions** *by Lester Grant*  
35 **Pathsetter in National Pedagogy** *by Julius Richmond*  
37 **Health Care in the Year 2000**  
37 **Passing the Pursestrings: the Economic Powers To Be**  
*by Mitchell T. Rabkin*  
40 **Cost Shock: Back to the Future of Patient Care**  
*by Gordon T. Moore*  
42 **Necessary Distractions: Malpractice, For-profits, and Measuring Quality of Care**  
*by Francis H. Burr*  
45 **Doctor William**  
*a poem by Linda Covell Davis in collaboration with Lewis Carroll*  
46 **Minority Experience: Faculty Perspective**  
46 **The Race for Credibility**  
*by JudyAnn Bigby*  
48 **Taking Care of the Ladies**  
*by Nancy Oriol*

## FEATURES

- 3 **Alumni Council: President's Report** *by James A. Pittman Jr.*  
5 **Alumni Council: Past President's Report** *by Clement Hiebert*  
7 **Letters**  
9 **Campaign Report**  
11 **Pulse**  
14 **Bookmarks: Storm Over Biology** *by Bernard D. Davis and Beyond Appearance: Reflections of a Plastic Surgeon* *by Robert M. Goldwyn*  
50 **Alumni Notes**  
59 **In Memoriam and Death Notices**

Cover: Photograph of Dean George Packer Berry by Yousuf Karsh



# INSIDE H.M.A.B.

**H**arvard Medical School has been fortunate in its deans. They have been cast in diverse moulds, many from Harvard, three from away. George Packer Berry, dean from 1949 to 1965, plays the leading role in this issue. A graduate of Princeton and Johns Hopkins, he was called from Rochester by Harvard president Conant. He retired from HMS deanship back to Princeton where he lived and served until his death this past winter. George Packer Berry was a strong figure who, as dean, became closely involved in alumni affairs. A memorial service for him was held in the Faculty Room in December, and we invite alumni to join us in a similar tribute here.

Last fall, Harvard celebrated its 350th with friendly pomp and circumstance, and a very large array of symposia. In these symposia, two of our alumni, Mitch Rabkin '55 and Gordon Moore '63, predicted what medicine would be like in 2000 A.D. We print their predictions here, as well as a speech by Francis H. Burr on some of the predicaments faced by health care providers. Burr was a long-time member of the Harvard Corporation and is now retiring as chairman of the Massachusetts General Hospital's board of trustees.

We couldn't refrain from what Gilbert and Sullivan might designate that "annual blister"—doctors giving expert testimony in court. Frank Reardon, counsel to CRICO, Harvard's malpractice insurer, and Thomas Gutheil '67, no stranger to these pages, lead the way.

There is more: thanks are due to Debra Trione for her dedicated work in filling the gap left by Lisa Drew, off to seek her fortune in New York at *Newsweek*. Lisa leaves with our thanks for a job well done. Now Ellen Barlow has joined us as managing editor. Your editor rests content.

—Gordon Scannell

# HARVARD MEDICAL

## ALUMNI BULLETIN

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# ALUMNI COUNCIL: PRESIDENT'S REPORT

## How Many Doctors: Class Size and Eudistribution

by James A. Pittman Jr.

In June 1985 I attended a meeting of class agents as a guest of Dorothy Newell, the pleasant and efficient Mother Superior of all class agents. At that meeting one class agent, from a class in the 1920s or '30s, asked, "When is Harvard Medical School going to move into modern times and do the right thing by reducing class size?" Since he was a class agent committed to raising money for HMS, he was obviously also committed to maintaining HMS as a standard bearer of excellence in medicine.

Is HMS avoiding its proper commitment to excellence by refusing to reduce class size in the face of so many predictions of an imminent "doctor glut?" Are we ducking the issue? I think not.

This call for a reduction in medical school class size is often heard among physicians and medical school faculty members who feel both threatened by a surfeit of physicians and overcommitted to large numbers of students in their schools. It is stimulated by genuine and deep concern over the increasing coalescence of practicing physicians into large groups and organizations which are primarily business-oriented, and by the increasingly cut-throat tactics used by these organizations (aggressive advertising, cornering of patient markets, reducing the discretionary options open to both patients and physicians, setting of production quotas for their employed physicians). They are also concerned about the atrophy of clinical skills engendered by overdispersion of patients so that no single physician or group maintains enough experience, and the tendency of a surfeit of doctors to promote these trends.

There are several problems with reduction of class size in any single medical school as a remedy for these

ills or even as a remedy for the doctor glut which may aggravate them:

1. Reducing class size in any single medical school has essentially no effect on the doctor glut, especially if this is offset by increases in other schools.

2. Reducing class size decreases the resources available for operating a school.

3. Reducing class size in good schools like HMS may result in a smaller proportion of well-educated physicians in the U.S., hence a degradation in the quality of care.

*Reducing class-size at schools like HMS may result in a smaller proportion of well-educated physicians.*

4. Reducing the production of physicians and maintaining a low per capita density of physicians in the U.S. encourages the independent practice of "health care providers", considered by many physicians to be less capable of providing such care.

5. Who said "too many doctors" anyhow?

The large numbers of poorly trained physicians and for-profit "medical schools" of the 1890s and first decade of this century receded under the impact of the Flexner revolution and the advance of scientific medicine, encouraged by the economic depression of the 1930s. The 1930s also saw the establishment of most of the specialty boards now in existence. Some concerns were expressed in the 1950s about a shortage of physicians, but only after the enactment of Medicare and Medicaid in

1965 did these cries over a "doctor shortage" become shrill. The 1970s saw major expansions in both the number of medical schools and the class sizes in existing medical schools. My state, Alabama, produced less than 80 new medical graduates in 1970, but it produced more than 240 in 1980—a 300 percent increase! The 1970s also saw a massive infusion of "new health practitioners," intended to function as "physician extenders." These included physician's assistants, nurse practitioners, nurse clinicians, clinical pharmacists, expanded role optometrists, and so on.

Not only was the U.S. increasing its M.D. production, but it was also removing barriers to immigration by aliens holding M.D. degrees or their equivalent. In 1972, 46 percent of the newly licensed physicians in the United States were neither born nor educated in the U.S., and by 1975 nearly one-fourth of all the physicians in the country were Foreign Medical Graduates (FMGs).

In this climate, concern grew over a "doctor glut," and in 1976, the Graduate Medical Education National Advisory Committee (GMENAC) was established to advise the federal government on the proper number of physicians, the proper distribution by specialty, and the proper distribution by geography. In other words, the concept of "maldistribution" implied the concept of "eudistribution," the idea that somebody could determine exactly the correct number in aggregate, by specialty, and by geographic region. After four years of labor by some 1,600 people and the expenditure of about \$8 million, GMENAC recommended a 17 percent reduction in entering class size and that no new medical schools should be established.

I was on GMENAC and took its conclusions seriously, so it was easy to convince our school to reduce entering class size—from 165 to 150



(nine percent), in 1981. However, the aggregated national entering class size increased this same year, and a new medical school was opened in Macon, Georgia. Reducing class size at our school may have helped slow the growth ever-so-slightly, but as measured against the GMENAC recommendations, it accomplished nothing at all. It was offset by increases elsewhere in the system.

Four years later, we had 60 less students in the school. At \$4,000 annual tuition, we had some \$240,000 less per year to operate the school with. In addition, since virtually all formulas for state or federal funding of education started with the number of students, we lost some \$1 million annually from that source as well. Thus, the "reward" to the school for our socially conscious effort was a reduction in the funds by about a million dollars a year!

In addition, I can (or could, if not prevented by law and policy) give you the names of young men and women who would like to be physicians but had poor academic credentials, failed to gain admission to American medical schools, went to some school in the Caribbean, obtained an M.D. degree of dubious worth, then returned and are now practicing in the United States. Some of these people are perfectly fine individuals who simply did not get their acts together until after college or had other difficulties, and they may be good physicians. Others are of dubious, marginal abilities and will, in my estimation, continue to be plagued by professional problems in the future. Does this enhance the excellence of American medicine?

Fourth, estimating exactly the right number of physicians is an exercise in futility without a very large set

of assumptions; estimating exactly the right number for each specialty is even more difficult. Should orthopedic surgeons or neurosurgeons provide surgical care for ruptured intervertebral discs? Should dermatologic surgeons with no general surgical training remove nevi which might be malignant, if given access to an operating room in case more extensive surgery is required? Should head-and-neck surgeons with ENT training alone do face lifts, or should only plastic surgeons do this? Should only those oral surgeons with an M.D. degree be given operating room privileges? Should family physicians deliver babies, and under what circumstances? Should optometrists be licensed to use drugs for diagnostic or therapeutic purposes (as they already are in some states)? Should independent nurse practitioners bill third party payers separately without reference to any physician? Should pharmacists handle "routine" prescriptions (e.g., manage hypertension, diabetes, or chronic congestive heart failure)? Until such questions about who is doing what can be settled, attempts to define numbers are futile.

The question of geographic distribution might be settled, at least theoretically, by laying a grid out over the country so that no point is farther than, say, 25 miles from a clinic staffed at all times by a physician and a nurse, with adjustments for population density. However, the federal government is not likely to assume this level of control over medicine in the near future. Besides, an interesting study by the Rand Corporation has shown that 98% of the U.S. population is already within 25 miles of a physician.

Finally, the general public does not support reductions very vigorously, though they do claim to advocate saving money. When my school made the modest reduction of 9 percent in 1981, we had to appear before the local Health Systems Agency (HSA), of the planning system to obtain permission. The first meeting of the HSA was picketed so violently that the meeting had to be adjourned and reconvened two weeks later. At the second meeting, the vote permitting us to reduce class size passed by only 15 to 14. The picketers claimed that the rich doctors were just trying to protect their incomes. While the public is probably more sophisticated in 1987, there still seems to be no great enthusiasm to reduce classes. As for actually closing medical

schools, this is next to impossible. They are local pork barrels, and it's easier to close an air base, a navy yard, or army base than a medical school.

What has Harvard done during all this turmoil? I am proud to report that during the hectic temptations of the 1960s and '70s, HMS did not change its number of graduates. That number has remained about 165 ever since World War II. As the two-year "basic science medical schools" of the West and South developed into four-year schools in the 1950s, '60s, and '70s, HMS stopped taking transfer students into the third year and increased first-year size (thus qualifying for some government grants). Since tuition at HMS is now slightly more than \$14,000 annually, a reduction of 25 students per class would, after four years, result in some \$1.5 million less annually to run the school. No, Harvard has not ducked the issue. It has done just right.

On 18 July 1983 I wrote the Liaison Committee on Medical Education (LCME), which accredits American and Canadian medical schools, requesting that they grade the schools, as had been the practice during the early part of this century when we were trying to upgrade quality and reduce quantity. On 27 October 1983 I received a polite letter declining my suggestion with the observation that grading "had the potential for creating significant problems for schools." If closing a school is a "significant problem," they're right. That's exactly what I had intended.

The LCME is sticking with its pass/fail system and failing no one. (The last school closed was Middlesex Medical College in Boston in 1946.) We can't look to them to help. They provide only minimal standards.

There is, however, one thing that will reduce entering and ultimately graduating class size: fewer applicants. The number of applicants to medical schools has been falling lately across the country, and applications to HMS have been falling as well. Class size nationally, and graduation of physicians annually, will fall probably within 10 years. And this lack of applicants will be the main reason.

In the meantime, HMS will hold its steady course and continue to be a beacon for others. □

*James A. Pittman Jr. '52 is dean, professor of medicine, and professor of physiology at University of Alabama School of Medicine in Birmingham.*





# *Past* ALUMNI COUNCIL: PRESIDENT'S REPORT

## On the Banks of the Tigris

by Clement A. Hiebert

The prospect of a trip to the Arabian Gulf as a representative of the American Board of Surgery at the first-ever Arab Board of Surgery Examination in Baghdad was irresistible despite the somewhat daunting "aside" in the invitation—"there is a war going on where the Board Examination is to be held." The scariest time was not in the Near East at all. It occurred at the start when a downeast blizzard forced a harrowing drive to Boston, and I arrived barely in time to board the Swiss Air flight to Zurich. Eighteen hours later my magic carpet alit in Kuwait where Dr. George Abouna and a few representatives of the Ministry of Health were on hand to welcome me and ease my passage through customs and immigration.

Arrangements and hospitality were first-class all the way: chauffeured car; well-appointed hotels;

city, museum, and shopping tours; and multiple dinners and receptions in places as elaborate as the Oil Club and as gracious as the Abouna's home.

*President Hussein responded to the nurse shortage by conscripting all female university graduates for a year of hospital service!*

The temperature was a comfortable 65 degrees and the humidity low despite proximity to the Arabian Gulf. My driver told me that summer temperatures could rise to 130 de-

grees making even a "cold" water shower a scalding affair.

Dr. Abouna showed me around his modern transplant unit where candidates for livers and kidneys far exceeded donor supply. Conservative tradition, not law or religion, is blamed.

Kuwait has the highest per capita income in the world (\$20,000.00+); the wealth is reflected in gorgeous buildings, well-kept homes, spacious boulevards, and shops aglow with 22-karat gold baubles and pearls from the Arabian Gulf. Piles of Persian rugs can be seen in the market place where bargains abound.

I spent a couple of days savoring the sights of Kuwait and sorting out an eight-hour jet lag, then went off to Baghdad. Fighting only 25 miles from the Kuwait airport made a dog-leg flight necessary. I managed to erase the thought of a half million Iranian soldiers poised at the border.

In contrast to Kuwait, which appeared an altogether peaceful place, Baghdad held soldiers with machine guns, occasional wounded veterans on crutches, and the spectacle of buildings leveled by rocket attacks. One of these missiles had landed close to the hospital where examinations were to be held. This hospital was adjacent to the Department of Defense, but no bombs fell during the testing.

The purpose of my visit was to join Dr. Allan MacDonald, representing the Royal College of Surgeons of Canada, in authenticating the first examination by the Arab Board of Surgery. Fourteen of the original 23 candidates had passed their written qualifying test, the scope and content of which were similar to the Part I Examination of the American Board of Surgery. The certifying examination, which I was to participate in, had two parts: one clinical with live patients, and one practical with pathology and problem solving.



*The Minister of Health of Kuwait presents Clement Hiebert with a souvenir.*

## Walter B. Cannon

### *The Life and Times of a Young Scientist*

Saul Benison,  
A. Clifford Barger,  
and Elin L. Wolfe

This first biography of Cannon traces his life from his youth in Minnesota through the early years of his career as a professor of physiology at Harvard. In demonstrating his extraordinary influence on the development of modern medicine, this book illuminates Cannon's private and public labors and a dynamic and critical period in the history of medicine at Harvard.

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*Clem relaxing in splendor at the hotel in Baghdad!*

Attractive and smartly attired nurses' aides assisted us. The young woman assigned to my room explained in perfect English that President Saddam Hussein had responded to the shortage of nurses by conscripting all female university graduates for a year's hospital service! It turned out that she was an actress who appeared daily on television. She acknowledged making more on her off-duty job in one afternoon than she received for many weeks work as a nurses' aide.

The doctor from the Hotel Dieu in Lebanon had been kidnapped briefly and robbed at gunpoint en route to the Beirut airport. Minus his wallet, but finding his ticket and passport in place, he had continued to the airport and flown on to Baghdad to participate in the exams. "I have been kidnapped before!" he explained to me later. During the grading session, I held my breath lest politicking surface, but I came away convinced that the candidates who passed were indeed well qualified. Nine out of the original 23 applicants received certificates.

After the exams, there was much entertainment and adventure for Allan and me. I toured Babylon and visited Nebuchadnezzar's 382-room palace on the banks of the Euphrates River. Our professional archaeologist guide was the sister-in-law of one of the surgical residents.

Unforgettable, too, were the ba-

zaars with their seemingly endless alleys lined with stalls featuring carpets, gold, silver, hardware, antiques, spices, fish, and garden produce. The streets, no more than 15 feet wide, were unpaved and covered by tin roofs curiously evoking medieval shopping malls. Presiding over each shop were bearded Bedouins or black veiled and robed ladies. The scenes were straight from "The Arabian Nights."

As travels go, this trip was special: a combination of professional duties and exotic adventure. In the States, I am used to examining foreign candidates, but here, I was the foreign examiner and a representative of a country with an uneven track record in the area to boot. I was expecting polite aloofness at best, hostility at worst. Instead, I received honors and gracious hospitality.

Eastern flight 3822 from Boston touched down at the Portland International Airport at 7:05 p.m. Snow from the blizzard ten days before lay in drifts. Christmas was a week away. Headlines proclaimed that the U.S. was aiding Iraq with A.W.A.C. surveillance flights over Iran. □

*Clement Hiebert '51 is former president of the HMS Alumni Council. He is current chairman of the Department of Surgery at Maine Medical Center in Portland and is a senior member of the American Board of Surgery.*



## Laudatory Remarks

The latest issue of the *Alumni Bulletin* stands out as compelling reading. My wife (Margaret Ross '74) and I were deeply moved by the candor of the writers. Somehow, I feel this material has a higher priority for medical student and physician reading than much of the stuff we assign. Please accept our gratitude for crafting this deeply moving compilation. Our copies will circulate for quite some time.

—David A. Link, M.D., chief  
Department of Pediatrics  
Cambridge and Mt. Auburn Hospitals

From time to time I have wondered whether HMS could sustain clinical relevance if it were not attached to a scientific frontier or some social agenda. How welcome it was to read the breathtaking Winter issue on doctors as patients wonderfully introduced by Howard Spiro.

Doctors usually cannot bear to look out on the alien world of the sick through the eyes of an inhabitant. But when they do, their account of pain and fear is riveting and invaluable. This type of material, along with Martha Weinman Lear's incomparable "Heartsounds," the account of the long, final illness of her physician-husband, should be required reading for medical undergraduates everywhere.

—James S. Bernstein '52

The *Harvard Medical Alumni Bulletin* after all these years is still far and away the best magazine in the business. I was especially taken with the "Doctors as Patients" issue, notably, the Murray and Brice pieces. The *Bulletin* must have something that does not meet the eye to so entrance a Cornell man!

—Irvine H. Page, M.D.  
Editor Emeritus  
Modern Medicine

Thank you very much for putting out a perfectly wonderful issue.

—George E. Vaillant '59

I thought you did a fine job in shortening my piece and am writing to thank you. The whole [Winter] issue looks like a good one. Dr. Michael Kashgarian has recently taken over as editor of the *Yale Medical Alumni Bulletin*. I told him at dinner the other night how far superior to anything Yale produces in that line is your (our) alumni bulletin.

Very many thanks.

—Howard Spiro '47

Your article on Francis Peabody in the Winter issue of the *Bulletin* was excellent. Although I never knew him, his heritage was pervasive at Boston City Hospital not only through Castle, Minot, and Finland, but also throughout the house staff.

—Charles S. Davidson M.D.  
Senior Lecturer in Medicine, M.I.T.

I enjoyed reading your article on Francis Peabody. A patient of mine helped start a fund for the improvement of the care of the patient. We hope to teach everyone who comes in contact with patients how to help patients better cope with their illnesses and feel that everything is being done that should be done. We are considering expanding this to include caution about remarks made in recovery rooms and on the wards of hospitals in view of the surge in malpractice litigation. The official title of the fund is the Barnes Hospital-Joseph C. Edwards, M.D. Fund for the Improvement of the Care of the Patient. It is tax deductible for those who wish to contribute.

—Joseph C. Edwards '34

The Winter issue of the *Bulletin* on "Doctors as Patients" is of interest. The tragic experience recorded by Judith Alexander Brice shows that she was a difficult patient, but also outlines vividly the failure of her physicians to gain her confidence. It would seem that the failure to gain the confidence of the doctor-patient is a reflection of insecurity on the part of the physician in charge.

Many physicians who have never experienced a personal illness lack humility, and have difficulty understanding the doctor-patient's emotional reactions and critical tendencies. The physician who experiences a personal illness early on may be fortunate. Acceptance of a dependent status is enlightening and can add to future therapeutic skills. During the training period, time and effort should be directed toward helping the young physician gain personal insight that will lead him or her to better understand the patients' emotional needs.

—Augustus S. Rose '32

### Memories Again

Two used books and one-half sheet of paper, treasures from browsing in Harvard Square bookstores and the Countway archives, may embellish the elegant piece about Francis W. Peabody in the Winter 1986-87 issue of the *Bulletin*. The first is a reprint of "The Care of the Patient" from the March 19, 1927 issue of the *Journal of the American Medical Association*. On the blank page facing the front cover, in Peabody's handwriting, is the inked inscription: "To W.J. with love from F.W.P., Cambridge, July 31st, 1927." Less than three months before he died, Peabody gave this special volume to his dear friend, William James.



I also treasure another volume that I found on the same day for the same price (\$3.00!) in another store: a copy of a privately printed memoir by Peabody's father. A few years later, I found a handwritten note at Countway, dated August 2, 1927, from Francis W. Peabody to his father: "Just getting out of bed to go to the garden to meet Blumgart and tackle his paper again—we are having very good fun over it and I have the satisfaction of being pretty sure that I am contributing something to him. After all, if I can show a boy (Peabody was 45 years old, Blumgart was 32!) with a brilliant scientific future something about the presentation of his work, I am doing a well worthwhile job." Those of us fortunate enough to have had Herrman L. Blumgart (1895-1977) as *our* mentor, who enjoyed helping us with our papers, can savor this portrayal of him with *his* mentor.

The Peabody-Blumgart relationship started when, as a medical student at Harvard, Blumgart was invited to "learn really how to do research" with Peabody and Cecil K. Drinker (Blumgart to Linenthal); it continued when Blumgart was a medical intern at the Peter Bent Brigham Hospital (1921-22); and it flourished after Blumgart came to work at the Thorndike Memorial Laboratory in January, 1924. By the summer of 1927, Blumgart's studies of the velocity of blood flow, using the first radioactive tracer in medicine, had already established him as an outstanding investigator. In May, after Blumgart had declined an offer from the University of Chicago, Peabody wrote to dean Edsall: "In view of his refusal of an assistant professorship, I am recommending his appointment as a faculty instructor in the Department of Medicine. Dr. Blumgart's age, training, and excellent work on the circulatory velocity make him a desirable candidate for the position."

The paper on which the two men worked in the garden was probably one by Blumgart and Soma Weiss, either the ninth or tenth in Blumgart's series of "Studies on the Velocity of Blood Flow." Both papers dealt with the pulmonary circulation and provided clinical answers to questions that Drinker, Peabody, and Blumgart had addressed in the laboratory. The two papers were submitted to the *Journal of Clinical Investigation* on October 11, two days before Peabody died.

In 1928, Blumgart left the Thorndike for Beth Israel Hospital, which was just moving from Roxbury to

Brookline Avenue. At BIH he was in charge of Harvard teaching, the director of medical research, and a visiting physician for the next 18 years. Then, from 1946-62, he was physician-in-chief. In his 34 years at BIH, Blumgart, too, influenced countless students and physicians at Harvard and elsewhere. In 1963, Blumgart chose to introduce his George W. Gay Lecture on medical ethics, entitled "Caring for the Patient," by quoting the closing sentence from Peabody's classic lecture.

Finally, in 1973, as Harvard left Boston City Hospital, 45 years after Herrman Blumgart left the Thorndike to go to BIH, the university decided to move the Thorndike Memorial Laboratory to BIH. This remarkable happenstance was the last link in a circle: Thorndike-Peabody-BIH-Thorndike. (I have excerpted many of these details about Herrman Blumgart's career from a chapter on him in my book on the early history of BIH. I expect the manuscript to be completed later this year.)

—Arthur J. Linenthal '41

I was saddened by the notice [*HMAB* Fall '86] of David Rutstein's passing, but cheered by the thoughtful notes of Thomas Chalmers. As a student, I heard Rutstein lecture, and particularly recall his convincing evidence about the carcinogenic effects of cigarettes, presented at least 10 years before the medical profession in general formed a consensus. During those 10 years, I can remember wondering why the conclusions Dave Rutstein drew were not immediately acted upon.

In my final year of residency in pediatrics, Rutstein was my attending physician for a month at the Children's Medical Center, and another month at the House of the Good Samaritan. Unlike some, he was able to separate the science from the art of medicine—a separation crucial to the practice of good medicine. Shortly after he published his conclusion that steroids could not be demonstrated to be significantly different than aspirin in reducing the effects of acute rheumatic fever, I asked him what medication he would use for his daughter if she were to have an attack of rheumatic fever with carditis. He smiled and immediately answered: "steroids, of course."

Rutstein carefully explained that he had answered as a physician who

had seen moribund patients with rheumatic fever respond in a remarkably short time to treatment with steroids. He insisted that his view as a doctor was not a contradiction to his just-published stance as a public health authority. When one publicly advocated a particular form of therapy, it had to be supported with a properly designed, executed, and analyzed study; but a physician had only to consider the best interest of the individual patient. This important clinical point has served me well for many years as a physician and teacher.

I recall with particular fondness that last day of my residency at the House of the Good Samaritan—the day before I was to drive all the way to Seattle. Rutstein came by on an unscheduled visit just to wish me well. This role model, who could take time from his work as a scholar and attending physician at so many Harvard-affiliated teaching hospitals, had time for an act of kindness to a resident physician. Rutstein has created his own memorial in the lives of many of us.

—Warren G. Guntheroth '52

### Antibiotic Anecdote

The letter in the Winter 1986-87 *Bulletin* from my classmate, Henry Work '37, ("More on the Dawn of Antibiotics") stimulates me to offer one more anecdote on the Franklin Roosevelt Jr. sulfanilamide episode during the autumn of 1936.

When the President's son was hospitalized in the Massachusetts General Hospital, I, a fourth year student at HMS, also lay in bed at the MGH from the same affliction of acute maxillary sinusitis. Since I did not receive any of the new Prontosil, perhaps I served as an unofficial control for my more illustrious co-patient. By the time my own immune processes had conquered the bacterial invaders, I had had time to listen, by radio, to every play in every game of the current World Series.

A year and a half later, when I was an intern at the Pennsylvania Hospital in Philadelphia, the impact of the on-coming age of antibiotics was brought home to me. Fourteen boys from a local reformatory were admitted with acute meningococcal meningitis. We had just received our first supply of the English sulfa-drug "M & B," and we used this to treat the patients. Thirteen of the 14 patients

recovered. Since Hans Zinsser had taught us that the mortality rate from this disease was at least 90 percent, this therapeutic result was absolutely staggering! World War II and penicillin were yet ahead but the antibiotic age that was to revolutionize our professional lives had begun.

—J. Russell Elkinton '37

## CAMPAIGN REPORT

# Funding Student Aid

### Our Mistake

Thank you for welcoming the Class of 1990 with your Winter 1986-87 issue. Your article provided many statistics on our undergraduate educations, including institutions, majors, and grades, as attesting to the academic quality of the class. However, the fact that many students hold advanced degrees was not even acknowledged. Similarly, your roster of class members listed only our colleges, not the institutions where we received our most recent degrees.

These omissions give the unfortunate impression that a Harvard M.D. is the only advanced degree that "counts" with the alumni. In the interest of understanding and goodwill, I hope you will correct this impression.

—Elana B. Doering, Ph.D.  
(M.I.T. 1986)

HMS HST Class of 1990

### Fountain of Sparrs

Your earlier request for anecdotes from Sparr's drugstore recalled one little introduction to Boston involving my then roommate, Jack Cannon, and I. We decided one day to get a "milkshake" such as we had known all of our lives in Southern California—thick and made with ice cream whipped in an electric blender. We went to Sparr's, asked for milkshakes, and were served shaken milk. When we asked about the ice cream, the waiter said, in that accent that cannot be duplicated in the written word: "If ya wanna frappe (pronounced to rhyme with 'trap'), why na ya askfuhit?"

We admitted ignorance and went back to the delicious cuisine at Vanderbilt.

—William Pollock '43B

*"My father recently remarked that he spent as much for our first house as I've taken out in loans this year."*

—HMS student.

Close to 70 percent of students at HMS required financial aid last year—a percentage that has been as high as 80 in the past five years. "Tuition at HMS has nearly tripled since 1977," notes Teresa Orr, director of Financial Aid. "Inflation made the costs of running the school increase exponentially at the very time we saw the retrenchment of federal support."

This financial picture is dramatically different from that experienced by HMS classes in the past. Prior to 1960, less than a fifth of the class received financial aid, mostly in the form of scholarships.

Tuition was \$5000 in 1977-78; \$14,850 in 1987-88. To pay these spiraling costs, many HMS students have gone deep into debt, often borrowing from several loan sources at once. Orr says that while a typical financial aid student had acquired a debt of \$55,000 at graduation in the spring of 1986, a few had accumulated debts up to \$100,000.

But the size of these debts is only part of the problem. "The *type* of loan is often as important as the *amount* of the loan," says Daniel Federman, dean for Students and Alumni. "The duration of repayment and the rate of interest are even more important than the amount. This includes such factors as whether interest accumulates while the student is still in training and whether interest is compounded."

The amount HMS gave students in low-interest loans more than doubled the last five years, to reach over a million dollars in 1986-87. But a student borrowing from HMS on the usual revolving student loan in 1986 is supposed to begin repayment on the seventh month after graduation.

Most students are not in a financial position to repay these loans until much later in their careers. With money slated for financial aid raised by the Campaign, says Orr, "the school will be able to absorb some of the loan costs on HMS revolving loans and let students defer payment until they have completed at least two years of post-graduate training."

One of the primary goals of the Campaign for the Third Century of Harvard Medicine is to increase funds

*A typical financial aid debt at graduation in 1986 was \$55,000, but a few debts were as high as \$100,000.*

for financial aid. The national campaign committee has targeted \$16 million and, as of April 1987, \$4 million had been raised.

The federal government has been a key player in the changing financial aid scene. Federal monies have been a major source of support for private medical schools by funding biomedical research and training, and special financial programs for students.

In the early '60s, a federal program offered low-interest loans to economically disadvantaged medical students. In the late '60s and early '70s, both loan forgiveness and scholarship support became available to individuals who agreed to practice in medically underserved areas, and the armed forces offered scholarships in exchange for service. In addition, the



Federally Insured Student Loan program made loans available to all families without regard to need.

After 1965, however, federal support to financial aid began to decline sharply. The fall was partially offset by the government's "capitation" program in the 1970s, which provided

*"We are taking steps to avoid a time when our student body reflects ability to pay more than potential for medicine."*

medical schools with subsidies per student enrolled to encourage enlargement of medical school classes. But that program stopped when predictions of a physician glut replaced forecasts of a shortage. Low-cost government loans for higher education are no longer so readily available.

General inflation during the '70s

also took its toll. Just when the costs of attending medical school began to escalate, responsibility for payment shifted from the family to the individual student. Now families are typically able to provide less than 20 percent of costs, and the difference is taken up by obligations acquired by the student.

"HMS is taking steps to avoid a time when its student body reflects more its ability to pay than the students' potential for medicine," says Federman. "But the sources of support that once allowed students of

modest or little means to attend private medical schools are drying up."

The cumulative indebtedness of students at HMS may threaten the achievement of Harvard's most cherished goals: the hope to draw students from all over the country, the desire to admit students without regard to their ability to pay, the freedom of students to choose their fields without economic constraints, and the hope that graduates will work with underserved groups. These are the issues at stake as Harvard Medical School enters its third century. □

## MOVING?

Please fill out this form and send to:

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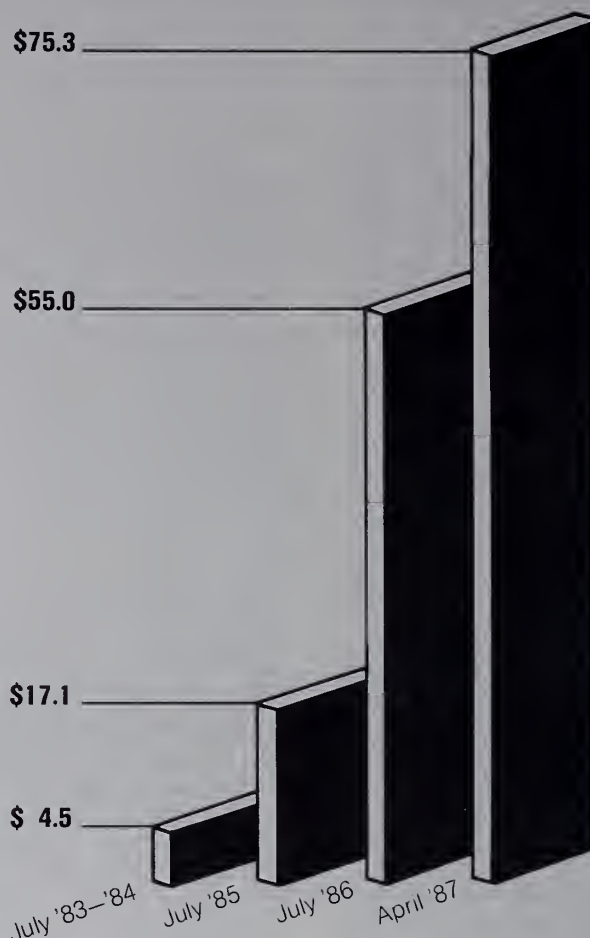
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## CAMPAIGN PROGRESS in millions



*The Campaign for the Third Century of Harvard Medicine had raised \$75.3 million in gifts and commitments by April 1987. The Campaign goal is \$185 million.*



## Suit Named First Soriano Professor

Herman Suit, a renowned radiobiologist who has made advances toward more effective radiation therapy for cancer patients, was recently named the first Andres Soriano Professor of Radiation Oncology at HMS and Massachusetts General Hospital. Chief of radiation medicine at MGH, Suit initiated three procedures to improve radiation therapy through "superior dose distributions," which more accurately target the tumor, sparing normal tissues.

In the early 1970s, Suit started a fractionated proton beam therapy program that has been effective in treating malignant melanomas of the eye and sarcomas of the base of the skull and along the spinal column. In this program, protons accelerated to half the speed of light are deposited precisely in the patient's tumor. Such precision is possible because protons, unlike X rays, have a finite range in tissue.

Several years later, Suit implemented intraoperative electron beam therapy as a complement to surgical resection of tumors of the abdomen and pelvis. The addition of intraoperative electron beam therapy to the treatment program has doubled the survival rate (from 25 to 50 percent) among patients with primary and inoperable carcinoma of the rectum.

Other findings by Suit and surgeons on the MGH sarcoma team have led to major changes in treatment for patients with sarcoma of soft tissue (fibrosarcoma, synovial sarcoma, and liposarcoma). Suit's team found, for instance, that combining moderate doses of radiation with conservative surgery provides local control that Suit describes as "at least as good as radical surgery, but with major improvement in cosmetic and functional results." Further, the team



*Herman Suit*

has strong evidence that, in treatment of these soft-tissue tumors, radiation is more effective when given before, rather than after, surgery. Radiation causes the tumor to regress slightly, and often encourages formation of a pseudo-capsule around the tumor, which facilitates surgical removal.

Currently, Suit is working with colleagues to devise strategies that will decrease the delay in wound healing among patients who have large tumors and who are elderly and obese. In addition, he is collaborating with researchers at Dana-Farber Cancer Institute to establish chemotherapeutic protocols for treatment of occult metastatic cancer. In the laboratory, Suit and colleagues are quantitating the dose-response relationship for radiation given alone and in combination with dose "modifiers" that may enhance tumor response to radiation therapy.

The Andres Soriano Professorship is named for the late Philippine indus-

trialist and U.S. patriot Colonel Andres Soriano, who died of pancreatic cancer at MGH in 1964. Shortly after Soriano's death, his sons, Jose and Andres II, established a memorial fund in his name. That fund, to which family, friends, and business associates of the late Colonel Soriano have contributed, has supported cancer research at MGH and at medical institutions in the Philippines for more than 20 years. It now endows the Soriano chair.

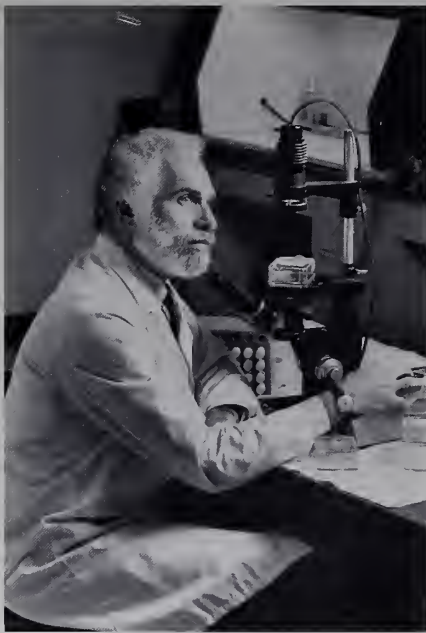
At a luncheon held to celebrate the new chair, Jose Soriano said that all those who contributed to the fund were committed to supporting research toward the eradication of cancer. But, he added, "We want the chair to go on long after cancer has been conquered. The day that cancer no longer exists, Harvard and MGH have agreed to redirect the chair to the leading edge of whatever problem or disease needs a professorship." □

## Berenson Philanthropy Funds New Professorship

Lowell Schnipper, chief of the Division of Oncology at Beth Israel Hospital, was recently named the first Theodore W. and Evelyn G. Berenson Associate Professor of Medicine at HMS. In both clinical and laboratory research, Schnipper has taken an aggressive approach to understanding the interrelation of viral disease and cancer.

This year Schnipper is on sabbatical from BIH, continuing his research as a visiting scientist at MIT's Cancer Research Institute. In the laboratory, he is using a retrovirus model to explore genetic processes important in the development of cancer cells. He is researching mutagenesis of herpesviruses when they are exposed to ultraviolet light or tumor-generating chemical agents, both of which appear to cause cancer by inducing rearrangements of DNA. In hopes of finding a key to intervention, he is trying to decipher the exact nature and the regulation of the genetic alterations.

In clinical research, Schnipper is exploring the use of high-dose chemotherapy and autologous bone marrow transplants. Schnipper and the oncology unit at BIH are cooperating with Emil Frei and colleagues at the Dana-Farber Cancer Institute to conduct controlled clinical trials of



Lowell Schnipper

high-dose chemotherapy on patients with metastatic cancers which have not responded to conventional treatments.

"At one time, it was more radical to do something *less* than usual practice," comments Schnipper, noting BI's early commitment to the conservative treatment of breast cancer. Now, it is theorized that low doses of drugs or radiation during cancer therapy may not only be inadequate, but may also stimulate dangerous mutations in those cancer cells which do survive, enhancing the tumor's ability to resist drugs or to spread to other parts of the body.

Doses of chemotherapy which are too high, however, can be equally dangerous, destroying the patient's bone marrow and thus compromising the immune system. "Can we use this high-dose chemotherapy intelligently and safely?" Schnipper asks.

Schnipper and colleagues are finding promising answers. Leukemia has proven responsive to high-dose chemotherapy in combination with radiation treatment, often followed by bone-marrow transplants. Limited experiments in treating drug-sensitive solid tumors with a similar approach show considerable promise as well.

Benefactors Theodore Berenson and Evelyn G. Berenson began their philanthropic relationship with BIH, where the professorship will be located, more than two decades ago. A trustee of BIH beginning in 1951, Mr. Berenson was named an honorary

trustee in 1968 in recognition of his leadership and generosity during a vital period in the hospital's growth. After his death in 1972, Evelyn Berenson continued to give generously to BIH. In September 1979, the hospital opened a new emergency unit with her financial support.

Evelyn Berenson has also endowed a building at the Hebrew Rehabilitation Center for the Aged and a chair in mathematics at Brandeis University, where she is a fellow. She has also given generously to the Dana-Farber Cancer Institute.

Theodore Berenson was founder and chairman of the board of the Berenson Corporation, former president of Edwin J. Dreyfus Properties, and a key figure in the development of Harbor Towers on Boston's waterfront. □

## New Anaesthesia Standards Set by HMS

Up to 2,000 people die each year in the U.S. from potentially preventable anaesthesia mistakes, according to a study headed by John Eichhorn '73, assistant professor at HMS and associate anaesthetist at Beth Israel Hospital. Though that number is small, relative to the 20 million people anaesthetized, it represents high costs in preventable deaths and in malpractice premiums, claims, and damages. Eichhorn's study indicates that 70 percent of indemnity costs for anaesthesia-related accidents could be avoided through implementation of new anaesthesia standards developed by the Department of Anaesthesia's Risk Management Committee. Those standards set a precedent for creation of similar national regulations by the American Society of Anaesthesiologists in October 1986.

Although some general guidelines had previously been published, these are the most specific, minute-by-minute standards of anaesthesia conduct yet implemented. The standards call for the constant presence of an anaesthesiologist or nurse anaesthetist in the operating room, the monitoring of blood pressure and heart rate every five minutes, and the continuous monitoring of ventilation and circulation. Other standards include continuous display of an electrocardiogram, the use of an oxygen analyzer, and the presence of means by which to check temperature. These standards

apply to "preplanned anaesthetics administered in designated anaesthetizing locations," excluding only epidural analgesia for women in labor or for pain management.

The Risk Management Committee says the standards should be applicable to "the smallest rural community hospital" as well as large institutions. "The standards had to be realistic, technically achievable, and affordable in terms of both personnel and equipment utilization," reads the study.

"Monitoring is far cheaper than insurance," says Eichhorn. Several Harvard-affiliated hospitals have purchased new equipment to facilitate implementation of these standards, but the committee estimates the cost should be only about \$5 per patient anaesthetized, compared to many times that amount to defend a malpractice claim.

The committee concluded that while not every detail of its standards would be universally applicable, they felt the process used to develop them and to achieve consensus on their adoption could be a useful model. □

## Doc of Ages Rocks the Hall

Tracing the illustrious history of medicine through a chronology that would make Thomas Kuhn shudder, the second-year students entranced and edified their audience this February with another "second-year show." Leading it off was a knock-out scene starring Neal Anderthal, who didn't "wanna be extinct," in search of Dr. Ooga Shaka, whose protocol turned out to be crude.

Then there was the couple who came to the city of David, which was called Beth Israel, and who lay their newborn in a manger because there was no place for them at the ICU. We met the Surgeon Mary, the Doctor's Mother, and her Son. ("Blessed are the weak of Heart, for theirs is the Kingdom of Digitalis. Blessed are the Hypertensives, for they shall inherit Diuretics.") "Com'mon J.C.," quibbled Judas at one point, "don't let your Dad do all the work—let's play God!"

In a Medieval hybrid between "The Sound of Music" and "The Name of the Rose," Sister Marion endeavored to uncover the mysterious cause of unsavory deaths among the brethren. ("She visits little chil-





Carey York as Sister Marian



Neil Levin as Neal Anderthal



Mark Agostini as the Reverend Gordon More-or-less



Bruce Daniel as Danny Tosteman. Tom Pereles as Dean Berries



Howard Francis as Aida Lottapasta



Swinging it up



The line-up

dren with a smile upon her face. On clinical rotations she's correct in every case.") With "How do you solve a problem like Urea?" the erudite sister probed all leads.

When the time-frame progressed to the twentieth century, the second-year actors dared to drop a few names. It was 1927 on the south side of Chicago when Johnny Honest's mother suffered a failing heart. Prohibition had outlawed medicinal drugs, and shady underground types hawked them outright on the street.

Johnny "a man's gotta do what a man's gotta do" Honest set out to find medicine and ended up breaking the clandestine drug ring of "smooth operator" Big Danny Federoni. (He "won't talk to his patients, just looks at their charts. You just need insurance, before he will start.")

The audience was delighted when a caricature of the late dean Berry, in a Broadway-style song and dance, taught successor Tosteson to "give 'em the old Razzle Dazzle." ("Give 'em the old double dean talk—daze

and dizzy 'em. Who can rebut a content-free remark? Razzle Dazzle 'em and they'll stay in the dark.")

Mark Agnostini gave a stunning performance as Reverend Gordon More-or-less. "When the skies were grey, Oh Lord, the New Path came our way, oh Lord, Amen. . ." A truly inspired Gordon bellowed testimony to a crowd of believers stationed in the audience below: "He revealed to me that there'd be no more disease, only illness."

The program states that the char-



acters represented in these skits "are purely fictitious," but that "any resemblance to actual persons, living or dead, is entirely intentional." A scene titled "Ferris Jenkins' Day Off" starred, among others, Walter Abdomen, and Daniel Tossed Salad. "Don't forget to stop by the office of educational gimmicks," they sang. □

## New Grant Reinforces Minority Student Programs

The Gustavus and Louise Pfeiffer Research Foundation gave the Minority Recruitment and Retention Program at HMS a boost recently with a grant of \$144,000. These funds are earmarked to help "prepare minority students for careers in academic medicine and training through research."

Alvin Poussaint, associate dean for Student Affairs, notes the important role the Pfeiffer Foundation has played over the last several years in supporting minority student research and minority faculty development. The foundation has been particularly important, he says, in encouraging minority students early in their careers. This new gift will continue and extend funding for the Pre-Matriculation Summer Research Program, in which minority students participate in laboratory research at HMS during the summer prior to their first year.

This new grant will also help support the student Biomedical Research Society, originally established by minority graduates of the MD/PhD program. The society hosts meetings that focus on research by minority students and issues of special concern for minorities. Meetings are open to the entire HMS community. Daniel Federman, dean of Students and Alumni, notes that the Pfeiffer gift will help the school capitalize on "our history of attracting strong students, and a tradition of training physicians for academic research."

Clifford Barger '43B is currently Robert Henry Pfeiffer Professor of Physiology. Barger praises Paul Pfeiffer, son of Robert Henry Pfeiffer and president of the foundation, for actively addressing minority issues. "In a time when so many people think the problems of minorities have disappeared," says Barger, "minorities are still in need of help." □

## Center for Blood Research

In May 1986, Harvard Medical School welcomed its most recent affiliate—the Center for Blood Research—into the fold. The agreement was the formal consummation of what had been an intimate relationship since the 1940s.

HMS professor of physical chemistry Edwin J. Cohn first formed the nucleus of the center by drawing together a large, interdisciplinary group to study the proteins in human plasma and to develop new systems for protein fractionation. Following Cohn's death in 1953, HMS formed the Blood Research Institute to continue his work; in 1972, the Blood Research Institute merged with the Blood Grouping Laboratory (founded by Louis Diamond '27), to become the Center for Blood Research.

Douglas Surgenor, author of *The Red Blood Cell*, a standard reference in the field, has been president of the center the past 13 years. Surgenor has been instrumental in developing national statistics about blood collection and transfusion, and is currently examining the effects of the AIDS epidemic on transfusion practices in

the U.S. At the center, Surgenor heads a research staff of 25 doctoral-level investigators working jointly with faculty from HMS, Harvard School of Public Health, Harvard-affiliated teaching hospitals, industry, and the federal government.

Center scientists, headed by scientific director Chester A. Alper '56, professor of pediatrics at HMS and staff physician at Children's Hospital, are also researching more effective ways to prevent the transmission of viral diseases (particularly AIDS and cytomegalovirus) through transfusion.

Senior investigator Harry Antoniadis, professor of biochemistry at HSPH, is heading a major project on the physiological functions of platelet-derived growth factor (PDGF) in wound healing, cell migration, protein synthesis, and other functions. Other investigators at the center are examining the chemical structure of PDGF to determine its role in cancer-causing viruses.

How will the new formal affiliation with HMS affect the Center for Blood Research?

"It is the best way for us to be sure we have the highest quality people in our institution," says Surgenor. □

## BOOK MARKS

# A Concurrence of Winds

*STORM OVER BIOLOGY: ESSAYS IN SCIENCE, SENTIMENT, AND PUBLIC POLICY*, by Bernard D. Davis, M.D., Prometheus Books, Buffalo, 1986

by J. Gordon Scannell '40

Fifty years ago, Bernard Davis '40 and I had rooms side-by-side in F-entry in Eliot House. I learned then that he was fearfully bright and also that he had a social conscience—he often brought my bicycle in out of the rain.

Fifty years have passed and we are both emeriti (he more than I in the academic thick of things).

In *Storm over Biology* Davis presents a fascinating collection of critical essays from the past. Many of these essays are book reviews whose primary aim is to distinguish truth from the near-truth proclaimed by distinguished scientists with high visibility and high-class media appeal. It is no surprise that Davis places sharp focus on Stephen Jay Gould, but E. O. Wilson, J. Watson, Sir Peter Medwar, and others are recipients also of his gently blunt but saving advice.

In Hilaire Belloc's phrase, Davis has a strict regard for truth, and in the past, this has led to controversy. The subtitle of this book might equally well have been "The Last Word."

Ten years ago, Davis was at the epicenter of a storm over affirmative action and *veritas* at Harvard Medical School. At that time, the *Bulletin* was significantly involved and finally came out on the Davis side of truth. Former editor George Richardson '46 observed that "we can only agonize as the two sacred cows of academic excellence and social justice gore each other in the public arena, with a third sacred cow, that of Dr. Davis's academic freedom, left bleeding on the sidelines." At long last, that bleeding is controlled and the wound healed.

Davis allows the reader to focus on particular issues: science; objectivity and moral values; evolution and sociobiology; ethics and molecular genetics; genetics, racism, and affirmative action in medical education; public concern over science and genetic engineering. Well along in this array, we come to a delightful critique of Stephen Gould's dissection of Jeremy Rifkin, with Davis in the role of Defender of the Faith against 'science for the people'.

I'm sorry Davis did not see fit to include the lively address he gave on Alumni Day in 1980—"Genes, Ghosts, and Goblins." (This essay can be found in the August 1980 issue of the *Bulletin*.) In this address at an alumni level, he dealt with all the irrational fears of recombinant DNA and genetic engineering. Davis has a keen, if at times serious, sense of humor. "Some time ago," he concluded, "I had a heated debate over this topic with a colleague. He fears most a Hitlerian misuse of genetics. I fear, on the other hand, that abandoning the search for objectivity and rationality increases the likelihood of falling victim to those who would think with their blood. But despite these opposite views, we have the same moral concern. Moreover, we have similar backgrounds: if his parents had not left Germany, and if mine had not left Russia a generation earlier, we might both have become cakes of soap."

*Storm over Biologr* is a handy book of reference, but it is not for casual reading. Most of the arguments demand a high level of special knowledge and a strict regard for the rules of logic. If you will put on your think-

ing cap, you will be rewarded by a very positive and intelligent statement of deeply held convictions. There is little compromise with the bumper-sticker campaigns of the anti-science

*This book is for  
intelligent people. . .  
be sure to get your  
prokaryocytes and  
eukaryocytes in line.*

establishment. It is eloquent testimony that Harvard opinions are not homogenized.

Davis may find it difficult to convince all readers to relax about the unknown. The scientific community can deal with uncertainty, but by

exploiting the unknown, Davis's chief adversary, Jeremy Rifkin, has the weather gauge. In the chapter "Genes and Souls," for example, Davis paints himself into a corner on the "unlikely" hazards of eugenic and germline intervention. People have a way of thinking the unthinkable. Consider his treatment of the "Andromeda Strain." We feel reassured by his friendly *E. coli*, but we are hung up when we try to match remote possibility with zero probability. When this is translated into epidemics, the public can easily run scared—AIDS for example.

One reviewer (William Tucker of the *Wall Street Journal*) has correctly pointed out that Bernard Davis is the kind of professor the world needs; he is interested in truth rather than mass movements. Even in academia, this attitude can sometimes get you into trouble, but Davis has no problem coming to his own defense. This book is for intelligent people; but before you read, be sure to get your prokaryocytes and eukaryocytes in line. □

## Skin Deep

*BEYOND APPEARANCE:  
REFLECTIONS OF A PLASTIC  
SURGEON*, by Robert M. Goldwyn,  
M.D.; Dodd, Mead and Company;  
New York; 1986

by James W. May, M.D.

Robert Goldwyn '56 tells of the process of plastic surgery and much more in the 229 page, hard-cover book *Beyond Appearance: Reflections of a Plastic Surgeon*. This book is autobiographical but not an autobiography. Goldwyn outlines a typical day in his professional life. In discussing encounters with patients, he is refreshingly open, revealing many of his most personal thoughts and feelings. He

shares with the reader his philosophy of life and his interpretation of the behavior he sees around him.

The style of this book is casual, witty, and palatable for lay and professional readers alike. The nature of esthetic surgery is exposed and dissected with candor. Before he is through, Goldwyn discusses most of the important issues facing surgeons and patients today: doctor-patient selection, conflicts in medical school between full-time and part-time faculty, malpractice, honesty, money, advertising, appearance, sex, and even nuclear war.

I am sending a copy of *Beyond Appearance* to my parents. I have never been able to explain my chosen profession to them as fully and entertainingly as Goldwyn has in this book. □



# THE ADVERSARIAL GAME: *Step by Step Strategy for the Expert*

by Thomas Gutheil

**Psychiatric witnesses are like bananas: you can buy them by the bunch—Nationally known trial lawyer**

To the average physician, the very notion of being called on to testify in court—for any purpose, at any time, under any circumstances—must rank in desirability and pleasurable anticipation somewhere below undergoing major root canal surgery without anaesthesia. Yet the role physicians play in court is a time-honored one, and some theoreticians believe the legal system could not do without consultation from us.

Their need for consultation stems from a point in legal theory which holds that some matters—fingerprint identification or the standards of medical care, for instance—are so complex that they require the specialized knowledge of an expert. The expert's role is to teach the jury how his particular profession views such issues so that the jury, thus educated, can assess the matter for itself.

Most physicians find the public display of disagreement between experts (so necessary to the operation of the law) embarrassing and a threat to the very credibility of the medical profession. Expert witnesses are often decried as "hired guns," who sell their clinical opinions venally for a fee. These perceptions persist despite the fact that expert witnesses on both sides represent a high level of solid professionalism and authentic clinical expertise.

The adversarial way of thinking is somewhat foreign to those of us not steeped in legal reasoning. It is common for physicians, who find the "battle of experts" distasteful, to suggest



*Doctors in Court*

# EXPERT TESTIMONY

## *Doctors in Court*

Few subjects are more volatile in medical circles than that of doctors who give expert counsel or testimony in court. Many physicians blame skyrocketing malpractice premiums on their peers who testify, especially as plaintiff's witnesses in malpractice disputes. Others distrust the adversarial system by which the law operates, and the new set of ethics that such a system evokes.

In response to this kind of opposition, we asked Thomas Gutheil '67, a psychiatrist, author, and seasoned expert witness, to defend the necessary role expert witnesses play in the administration of justice. He also explains the protocol a physician acting as expert witness might follow, from the initial telephone inquiry to the courtroom itself.

In 1976, the medical institutions affiliated with Harvard formed their own insurance company and risk management foundation in the hope of reducing professional insurance rates for all doctors working in their system. These institutions shared the conviction that through rigorous peer-review procedures and critical assessment of their own standards of practice, they could effect both better patient care and fewer valid, sustainable malpractice claims. Studies indicate that they were right.

When cases are filed within the Harvard-affiliated hospital system, and an attorney is needed, Frank Reardon is one of two lawyers to turn to first. Reardon is litigation counsel to the Harvard Risk Management Foundation. He shares his inside perspective on the malpractice crisis, physicians who testify in court, and how and why court decisions are made as they are.



that one expert, or panel of experts, work independently—as an *amicus curiae* (friend of the court)—to advise the legal process in a non-partisan way. This notion is usually rejected outright by the court because it plays against the legal system's distrust of non-adversarial "end-runs."

It is essential to remind ourselves that the adversary system is one of the bedrock elements of the law. This adversary system occupies a conceptual slot so central that it runs parallel to *primum non nocere* in medicine—an absolute given. Once one has grasped this, one can not be surprised to find an expert on each side of each case.

Most legal cases are extremely complex and ambiguous: it is rarely inarguably obvious which side is right. The responsible expert considers both sides before coming to an assessment. In trial, each expert must give the jury a sophisticated and simplified version of the real medical picture. One can visualize one expert drawing from the knotted tangle of material representing the case, those elements supporting the plaintiff's side, and another expert picking those elements which support the defendant's case. When each expert has presented his or her side fully, it is in the jury's hands which side to believe.

Even hired guns have their role to play as I learned, to my surprise, one afternoon. Early in my career I had just completed a deposition (examination under oath, prior to trial) in a psychiatric malpractice case. On this occasion, I was testifying for the physician, and his attorney happened to give me a lift in his car to where my own car was parked. The attorney's "heck, I'm just a simple farm boy" manner masked an amazingly keen mind, honed over decades of trial practice. During the ride, I railed openly against the expert opposing me in the case, a man who, until he later moved out of state, was the most notorious hired gun in the psychiatric community. He was an embarrassment to the profession, I snarled, a whore who shamelessly sold himself to the highest bidder.

The attorney heard me out for a while and then interjected calmly: "I've used him a couple of times myself." I stared at him open-mouthed. I could not imagine a straight-shooter like him using a witness like that. He went on to say that there had been times when he had had cases so paralyzingly awful for his side that what he needed, in his

own pithy phrase, was "an expert who would just nod his head when I told him to."

His point was that, in the adversarial system, the need for opposing witnesses supersedes consideration of who the witnesses are. While we may disagree with this reasoning, it is not uncommon in the law. Attorneys construe their ethical mandate to be to represent their case as effectively as possible, using whatever resource will serve.

The following sequence of events should stand as an example of what actually happens when a physician transforms himself into an expert witness:

When the attorney first calls to



consult me, she outlines the bare bones of the case—a patient was discharged from a psychiatric hospital after treatment and, sometime afterwards, killed himself. His wife is suing the hospital and treating physician for malpractice (failure to practice within the standard of care for an average hospital or practitioner). This attorney's law firm works for the doctor's malpractice insurer. Will I consult on the case?

This first step is designed to give me a starting impression of the case. The attorney and I bat the case around a bit with questions and answers. I ask about documentation (it is extremely common for a case to stand or fall on documentation alone). She notes that the documentation is good, but that the record contains some confusing entries regarding restrictions and privileges. I reassure her that this is standard practice but that assessment of these elements must await closer reading. Here I am performing a paid consultation in a specialized area.

She asks how the case "feels" to

me. I suggest that, on this first reading, it seems that the case will turn on whether the patient proves—from the record—to have been competent to participate in aftercare planning. If the case appeared absolutely groundless to me, I would have said so, and my role in the process would have stopped there. Had that happened, the attorney could have gone one of two ways.

If she has worked with me before and trusts my judgment, the attorney may accept the predictive value of my reading and drop or settle the case so that it never gets to court. This apparently abortive outcome may actually be highly desirable, since the attorney may save time and money in the long run by not pursuing a futile goal.

Alternatively, the attorney may decide to "go for it" anyway. She may call another expert, or, in some cases, a dozen experts, before finding one to support her view of the case. While this search process may seem to select for "hired guns," it is not invariably so, given the complexities of cases already noted. The ethical expert sells time (is paid by the hour for time spent); the "hired gun" sells testimony.

I agree that the case has merit, contingent on details to be determined, and (given that I have the time free) I give the attorney the go-ahead to send a stack of medical records, legal documents, interrogatories, and/or depositions to me for my review. If my report, written after reviewing these, is "favorable," the lawyer may name me as her expert. If it is unfavorable, the attorney may then decide to drop or settle the case, or may again go expert-shopping. I estimate that the number of cases I "turn-down"—give the attorney the "bad news" that the case is, in my opinion, meritless—comes to between 10 and 20 percent of those I consult on.

As the case develops, I may examine new material, be deposed (examined by the other side under oath), or give actual testimony in court. The pitfalls and vicissitudes along the way are so numerous that only a small fraction of cases actually come to trial. This is a good thing, because the courts could not possibly handle all the cases that are filed without going under. The expert serves as an indirect "filter" comparable to other screens like tribunals.

In the present case, it devolves that the wife was actively planning to desert her husband when he suicided.



Her guilt leads her to pursue the case in an attempt to shift blame from herself to the doctor—a common psychodynamic mechanism in tort law. The case comes to trial and I testify in court. The other (the plaintiff's) expert is the number two hired gun of those still left in Boston. The jury finds for the doctor, and the case is closed.

Physicians who provide expert testimony struggle over the ethics that guide them. What should the role of the expert witness be? There are two model answers which partially compete. These models differ on the question of advocacy; both are generally considered ethical.

The first is the model of the expert as "advocate for truth." Under this model, it is irrelevant what has transpired in the case to date. The moment the expert takes the oath, he or she becomes a neutral advocate for truth, whether that truth helps or hinders the side which retained the expert.

The second model might be called "the expert as frank partisan." This model holds that neutrality is a chimeric and personal bias is ineradicable: one should accept the polarity of the system in which one works. The expert should tell the truth in an effective manner that advocates and strengthens that side of the case which has retained the expert, leaving it to the other side's expert to express the opposing view.

Despite the neatness of this dichotomy, most experts do a little of both in any given case, employing the same internal ethical compass they use to guide themselves in all clinical interactions.

The adversary system of the law has demonstrated repeatedly that in some areas of human knowledge it is impossible to do without expert witnesses. Since the law is an adversarial procedure, there will be "battles of experts" for some time to come. I hope this analysis will clarify some of the confusions surrounding the use of expert witnesses, and will diminish the discomfort some observers feel when—just as in the real world of clinical practice—experts disagree. □

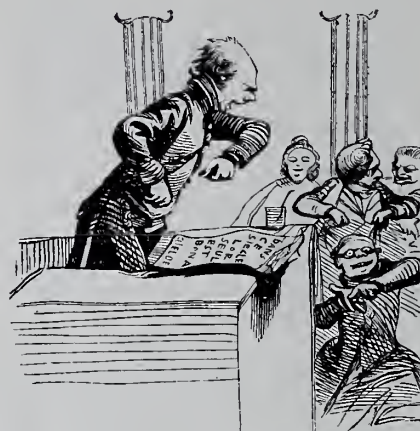
*Thomas Gutheil '67 is associate professor of psychiatry and co-director of Program in Psychiatry and the Law, Mass. Mental Health Center, Harvard Medical School. A nationally-known speaker on liability prevention, he has consulted on medicolegal cases in 25 states and has written extensively in the forensic field.*

# ***SPEAKING FROM EXPERIENCE: Interview with a Litigation Lawyer***

by Debra J. Trione  
and Frank Reardon

*What advice would you give doctors who are going into court for the first time?*

Number one, whenever you go into court you should tell the truth. That may sound simplistic, but the reason the jury system works is that juries have a real ability to know when somebody is telling the whole truth and when somebody is stretching it. You have to be satisfied that the position you're taking is the correct position. If it's not, it's going to come across very clearly to the jury.



Number two, be prepared. The worst assumption you can make is that the lawyer on the other side is naive about medical matters, that you are going to snow him with your superior medical knowledge. Generally speaking, the attorney who's cross-examining you from the other side will know as much about the specific medical issue on trial as you do about that issue. He will have read the

recent literature, and he will have had the advice of one or more experts who are just as expert as you. He will know what questions to ask, how to frame the questions, and how to lead you down the path of discrediting your testimony in front of the jury. You have to assume the lawyer knows a great deal about the case, and not be flip or give wise answers.

Finally, be as brief and direct as you can with your answers. It's like taking an exam where they pass out an entire blue-book, but the professor tells you he's going to stop reading it after the first page. So instead of putting in everything you ever knew about the subject, you have to concisely state your answer.

*Why has medical malpractice become such a big issue in the last 20 years?*

There wasn't much medical malpractice litigation prior to 1960 because one doctor would not testify against another doctor. Lawyers called it the "conspiracy of silence." If you had a doctor in Fall River who, you alleged, committed malpractice, you'd look for another doctor in Fall River to say, "Doctor Y deviated from the standards of practice in Fall River in 1957, and therefore, committed malpractice."

Naturally, it was difficult to find a physician to do that because 'people who live in glass houses shouldn't throw stones.' You're accusing Joe, who you've probably referred patients back and forth to, of malpractice. It didn't engender a sense of spirit among colleagues.

Eventually, the Massachusetts Supreme Court struck down the legal doctrine known as the "locality rule," and proclaimed that the standard of practice must be the same in all localities. The orthopedic surgeon from Boston could come in and testify as an expert against the orthopedic surgeon from Fall River.

Once this door was opened, doctors became willing to testify against other doctors, and the number of malpractice claims proliferated. Prior to that, if you went to court and couldn't produce expert testimony against the defendant doctor, the case was dismissed. You had no case!

*Is it common for two doctors to disagree about good medical practice?*

Yes, it happens every day of the week. That's what it's all about. I have a case right now involving an ankle fracture. In an ankle break, there's the



question of whether or not to screw the ankle together or let it mend by itself, and the decision hinges on the size of the break. One school says, anything over 20 mm should be screwed; another doctor says that anything over 30 mm should be screwed. And the break is 25. So they go into court.

You come in off the street; you're sitting there on the jury, and you have these two wonderful, reputable doctors: one telling you that 30 mm is the standard and the other telling you that 20 mm is the standard. Neither doctor is lying. There's a difference in philosophy in medicine, and the jury makes the final decision.

### *How do they decide?*

Somebody has to decide. It comes down to which doctor appears more credible to the jury.

When I search for an expert witness for a case, I might find a physician who is the most impressive guy in the world—on paper. He may be Harvard undergrad *cum laude*, Harvard medical *summa cum laude*, have served on presidential commissions, be head of his department. But when I go to meet with him face to face, something isn't there. Something doesn't gel. Something strikes me that whatever this doctor says will not sell well to a jury. That rapport, or that believability, won't be established.

I may go to another guy, who doesn't have as impressive credentials, but he's qualified to testify as an expert. When I sit down with *this* guy, something about his demeanor tells me that the jury will like him.

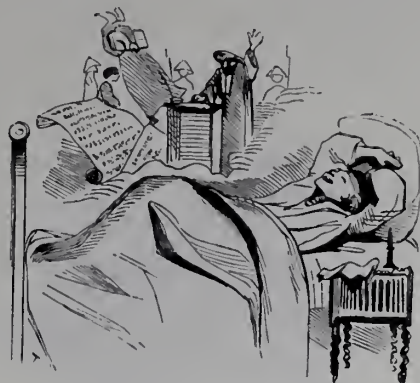
Maybe he looks like everybody's grandfather who would never lie to you in a million years. Maybe he looks like everybody's Marcus Welby. The people sitting there in that jury box will say, "Now there's a guy who's tellin' the truth. He'd never lie to you." As important as the credentials and the background, is that ability to make the jury feel that what you're telling them is the truth.

When I go out to pick my expert, I look for the person whom I think the jury is going to believe. And there are a lot of factors. If my opponent's expert is from New Mexico, and my expert is from Boston, what's your inclination? "If the practice in question is so common," you might ask, "why did he have to go to New Mexico? Why couldn't he find an expert witness around here?"

You can ask that doctor on cross-

examination how much he's being paid. That's a two-edged sword, because my witness is going to testify that I'm paying him, too. But if I'm paying my expert \$750 and my opponent is paying his \$5,000, well, maybe there's a reason that he has to pay that guy \$5,000.

You may ask that doctor how many times he has testified for either side. If he has never testified as a defense expert and he's testified 20



times for the plaintiff, that implies that any plaintiff can go to him and he'll say anything they want him to.

A good expert will have testified equally for both sides. If I ask him why he testifies for both sides, he will say: "I look to see whether or not the standard of care was breached. I look to see if I can justify the practice."

So the jury sits there and says, "Now here's a person who doesn't have an axe to grind; he enjoys doing this, and he feels he's doing a social service. If he thinks a doctor is innocent, he'll want to testify for that doctor; if he feels a doctor is guilty of malpractice, he'll go in and testify that way. He's being honest."

It's a big responsibility for a jury! The person who has to decide is the lay person. But they do it, and they do it pretty effectively. It's a good system. I don't know how else you'd do it.

### *Do some physicians give testimony just for the money?*

People often ask whether there are physicians who do this for a living—who will testify to almost anything. Yes, it is absolutely true. On the other hand, it is just as true that there is medical malpractice. There are physicians who testify as experts for the plaintiff because malpractice has

been committed. There are certainly good doctors who are good people who are not selling out.

Outside of the malpractice setting—guardianship proceedings, criminal proceedings—it is possible for the court to do an independent evaluation of the patient. And you hope, because court-appointed doctors are not retained by either party, that they will give you a more objective evaluation of the case.

But yes, there is a problem. Some doctors are willing to give opinions based on what the person paying them wants to hear. And it's not just in malpractice. Some doctors have developed lucrative side practices seeing patients who have been involved in automobile accidents.

Other doctors may think that the malpractice crisis is out of control and that they ought to testify as defense witnesses to quell that problem. Doctors from out-of-state may relish the opportunity to challenge a Harvard-based doctor, to show that their practice is as good as the Harvard doctor's.

As a doctor develops more of a practice along these lines, he loses his credibility. The more he supports one side or the other, the more he makes himself susceptible to cross-examination. The insurance companies come to know him; they question the legitimacy of his diagnosis.

I don't know if there's as much of this random testifying, or "testimony-for-hire," as you might think. There are legitimate cases out there, and there are legitimate differences within the practice of medicine. That's why things end up in court.

### *Do the hospitals affiliated with Harvard have a policy about what makes an expert an expert?*

I think there has been concern at some institutions within the Harvard system about doctors testifying in cases where their expertise is questionable or doctors taking positions that are questionable. When you put an expert on the stand, you qualify him as an expert by where he went to school, where he did his residencies, where he did other fellowship or post-residence training, and by where he is on staff now, plus his length of time in practice, research, and publications.

You really are selling the fact that you are qualified by your education and experience at these institutions. Some Harvard hospitals have ex-

pressed concern that when a doctor, who may not really be an expert, testifies, his performance reflects on the institution from whence he came.

#### *Who finally decides who is an expert?*

The judge. But the lawyers on either side can challenge that decision. A lawyer can stand up and say, "I move that all of this testimony be stricken, or that this doctor not be allowed to testify." Then it's up to that attorney to cross-examine the doctor, and to point out flaws in his education, training, or experience so that the jury thinks the doctor giving the opinion is not qualified, or that he doesn't have all the background necessary to give the opinion he is giving.

I just finished representing the plaintiff in the Brophy case, which involved a right-to-die issue. I disqualified a neurologist who came in and said that Paul Brophy was not in a persistent vegetative state. I cross-examined this neurologist for four or five hours to prove that, as a matter of fact, the court should find Paul Brophy persistently vegetative despite this doctor's testimony, because by his own admission, this doctor didn't understand the clinical phenomenon in question.

#### *How did you do it?*

I asked him if he had ever made the diagnosis of 'persistent vegetative' before, and he said he hadn't. Then I asked if he ever recognized the diagnosis, and he said he had never heard a definition of 'persistent vegetative' that he understood.

He was referring to a textbook he was co-author of. I found that that textbook was dated 1965, and I asked him if there were any pocket parts or any updates to that book. He said there weren't.

I asked if there was an index, and he said, "Yeh."

I asked if 'vegetative state' was in



that index. He looked and said, no.

" 'Vegetative state' wasn't even a diagnosis back in 1965, was it?"

He said: "No, we talked about varying levels of coma."

I asked if he was still active, and he said, yes, he still taught.

I said, "But you don't actively practice medicine, do you?" And he said, no, he'd been retired for several years.

I asked if he had had conversations with members of the staff where he worked and whether they recognized 'vegetative state' as a diagnosis. He said he thought some of them did.

I asked if they ever talked about 'vegetative state' at conferences he went to, and he said he hadn't been to conferences in a couple of years because he was retired.

But it took four hours to get through all that, and it was critical to my case. If I was going to prevail, I had to have the judge accept that.

When an esteemed doctor with a CV 10 pages long stands up there and, on direct examination, emphatically and forthrightly says: "This man is not vegetative," the impact of that on the court and on juries is incredible. The manner in which the attorney on the other side breaks that down is a very dramatic process.

## *Tale of Temptations*

The pejorative term 'hired gun' refers to a professional medical witness who prostitutes himself in favor of whichever side will pay the highest fee. But doctors of high principle and moral character often testify in court as well. Most often, attorneys seek expert counsel from physicians outside of court. Less frequently, they ask doctors to the stand.

Though it's all over-the-table and legal, many believe that some glitches in the system encourage less than honest testimony by doctors hired as experts. It's generally considered unethical, and in some states it's illegal, for doctors to give testimony on a contingency basis. If a physician's remuneration is set by the verdict, that physician may be encouraged to twist the facts a little. And a little twist of fact may

swing the case.

But, conversely, when physicians get paid for their testimony regardless of trial outcome, they may be tempted to take whichever side will pay the most. This happens often enough for all medical experts who testify to be targeted with slurs of dishonest conduct.

"We're talking money, and lots of it, at a time when doctors are getting squeezed," explains Dan Creasy, director of Harvard Risk Management Foundation. "A doctor can sometimes make \$25,000 in a single case—three to five thousand dollars a day. The absolute rock-bottom consulting fee is \$250 per hour. That includes the time for meetings, for reviewing the material, or even sitting in your living room thinking about it." Creasy points out that there is even

an 800 number attorneys can dial "to order expert witnesses by the size, age, and accent. There's just too much money involved for this not to happen."

Lawyers, in contrast, invest their own time and money in a case before it comes to trial. They can take as much as 50 percent of a several million dollar settlement if they win, and lose as much as \$50,000 if they don't. The more time and money invested in a case, the stronger the attorney's compulsion to pursue it to trial. As the trial date draws near, a lawyer who's already sunk thousands into a case may scramble to find a physician willing to testify on his side. Scrupulous physicians sometimes refuse, therefore, to participate in suits filed before they personally reviewed the case.



When the doctor said that, based on his examination, Paul Brophy was not vegetative, that judge called us into his chambers, and said, "What's going on here? Is he or isn't he?"

I asked the judge to let me cross-examine this doctor because I thought I could discredit him enough to show that my doctors were right. I had already had two neurologists testify that Brophy was vegetative; the medical record at the hospital had previously said he was vegetative on two separate occasions, and the attending physicians agreed that he was in an irreversible state.

That case was very disturbing. I saw the issue in that case as a societal one: do you let the feeding continue for a person in a vegetative state? I didn't see it as an argument about the diagnosis. If this doctor really believed that the diagnosis was wrong, it was appropriate to come into court to argue about it. But if he simply believed that the artificial feeding should not be stopped, then it was wrong to come in and say the diagnosis was wrong.

*Is it difficult to find doctors who will testify?*

To some degree, yes. I think, for both

sides, a network of doctors has been developed who don't object to testifying. Some doctors testify because they feel a social responsibility to do so. They feel there is malpractice out there and one of the ways to resolve this problem is to testify on behalf of the patient.

But a doctor is out there to practice medicine, and there are far more doctors who would prefer to practice medicine than would prefer to sit in a courtroom all day and bypass the practice of medicine. That's the norm. The exception is the doctor who likes



to spend his days testifying in court.

You know, every time a doctor goes into the courtroom, he puts his professional credentials on the line. That's uncomfortable. Somebody's going to stand up there and say: "That's not really a good medical school," or "You just do this for a living."

But I've never asked a reluctant doctor to testify on something he doesn't believe in. I've never had that happen. I have had to convince doctors who were reluctant because they don't like the courtroom setting.

I say, "Look, I think you'd be extremely effective. Your attitude is right. It's almost good that you don't want to go to court to testify. You're an acknowledged expert in this field and I need your help as does my client. We need your help and we'd really appreciate it if you'd come in and do it for us." And after you talk with them for a while, some say no, but most of them agree. □

*Frank Reardon, JD, is litigation counsel for the Harvard Risk Management Foundation, and a partner of Hassan & Reardon in Brookline, Massachusetts. He graduated from the Harvard School of Public Health with a Master of Science degree in 1981.*

Jack Coughlin, vice president of claims at Harvard Risk Management Foundation, believes that only a few of the many doctors giving expert testimony take dishonest advantage of the system. "Physicians have a social responsibility to lend their expertise toward the resolution of issues which can be dealt with only in court. They must not withhold, conceal, or distort information of which they are the sole proprietors. Legitimate malpractice claims exist, and the parties involved deserve sympathetic, professional medical counsel." As long as there are differences of medical and scientific opinion, Coughlin points out, there will be grey areas in which differing points of view will be presented in good faith by honest expert witnesses.

Statistics suggest, however, that unethical medical counselling does occur. In medical malpractice cases, for instance, plaintiffs lose four out of every five cases they file. If honestly advised from the start, most of these cases would never have come to court. A good medical expert will turn aside claims that could prove costly, lengthy, and painful to the attorney, the patient, and the defendant physician.

"Superfluous medical testimony is crippling both the medical profession and the insurance industry," admits Coughlin. "Doctors have to stop giving testimony to whiners. The malpractice crisis, which is nearly out of control, is costing all doctors—financially and in humiliation—just to catch the few who might have been negli-

gent, often inadvertently. The dilemma is triangular; it is common for medical professionals to point their fingers at lawyers and insurers while lawyers blame the doctors and the large insurance companies."

Fifteen or 20 years ago, most physicians refused to testify against their medical brethren on ethical grounds, arguing that they needed the freedom to exercise their own better judgment in borderline cases. They argued that even good medical practice can sometimes lead to unfortunate results. Attorneys balked and called it a "conspiracy of silence."

Now times have changed, and some believe that the problem has reversed.

—DJT

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# GEORGE PACKER BERRY

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## 1898 - 1986

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**D**ean from 1949 to 1966, George Packer Berry has been described as the right person at the right time for Harvard Medical School.

Much was accomplished during his tenure, not only for HMS but for medical education in general. He more than doubled the school's endowment, increased salaries and the number of tenured appointments, brought the affiliated hospitals closer together, and orchestrated the building of Countway Library. During the same period, he made a strong commitment to the improvement of higher education and served in a number of leadership roles, including president of the American Association of Medical Colleges.

Those who knew him spoke of his tremendous energy, his forceful and astute administrative skills, and his diplomacy in guiding controversial plans through committees. In 1957, the *Bulletin* reported: "With an expenditure of energy that even an Iowa corn-belt farmer might find difficult to emulate, dean George P. Berry is devoting his 'free' time to the preservation and propagation of what he terms the educational 'seed corn' of our nation."

In the following pages, we present sev-

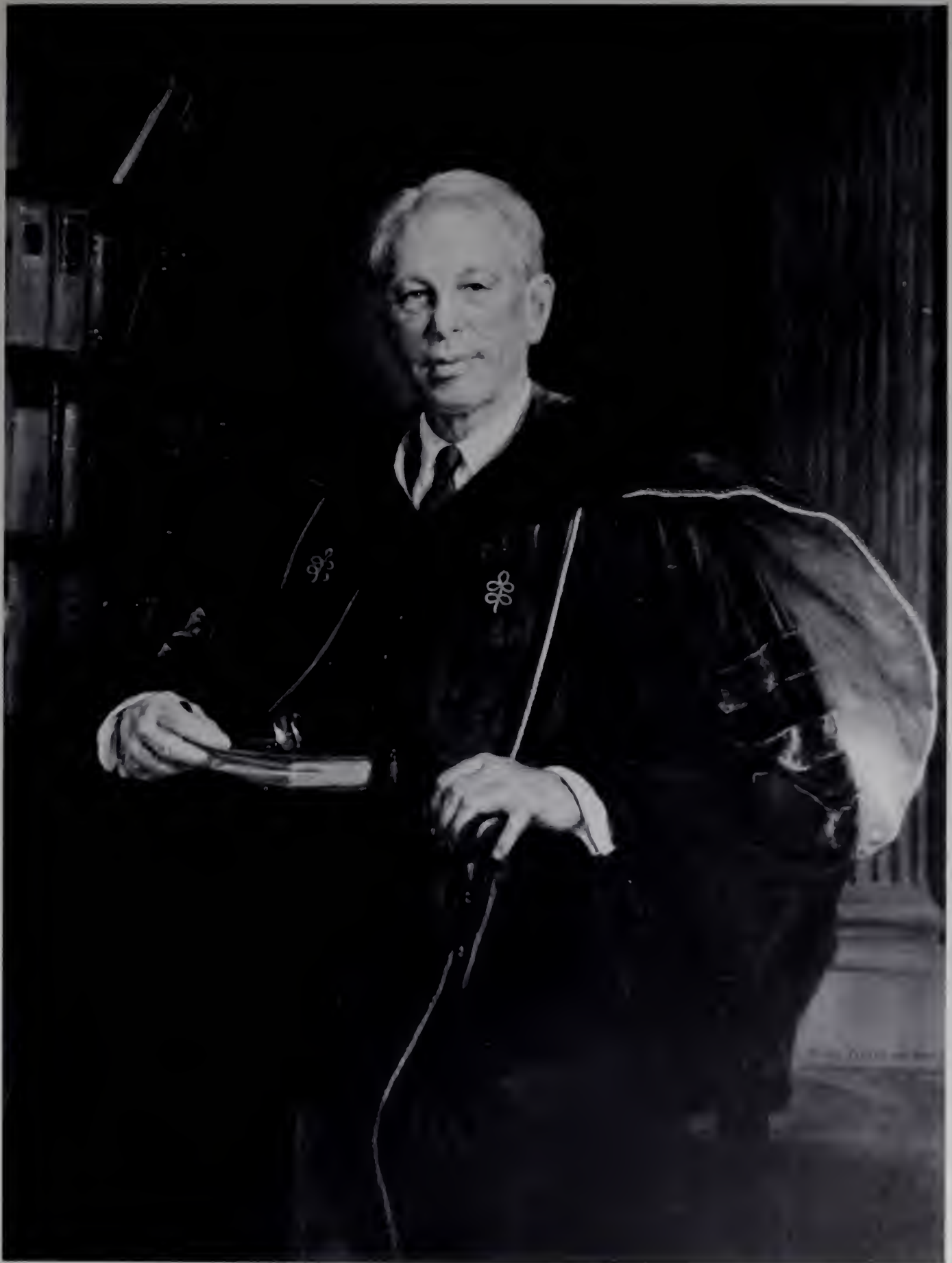
eral tributes to Berry, who died on October 5, 1986 in Princeton, New Jersey after a long illness. A memorial service was held for him at the medical school in December. Many who spoke at that service, as well as others who knew Berry well, agreed to

share their remembrances.

Berry the scientist is viewed through the eyes of Harold Amos who became an instructor in the HMS Department of Microbiology in 1955. Robert Goheen, former president of Princeton University, sends a formal tribute to Berry, describing his vigor and dedication. George Thorn, who served under five medical school deans, offers three vignettes that illustrate Berry's administrative powers and breadth of concerns.

Charlotte Litt reminisces about her teacher and mentor in the Department of Bacteriology & Immunology at the University of Rochester Medical School; Roy Greep about Berry's interest and involvement in the School of Dental Medicine. Lester Grant, who served as an assistant to Berry while a medical student in the '50s, talks about the dean's humanist nature. And Julius Richmond describes Berry's intellectual curiosity, his charisma, and his contribution to medical education on the national level.





# DEVOTED TO SCIENCE

by Harold Amos

**G**eorge Packer Berry was born in Troy, New York, on December 29, 1898, the son of Reverend George Titus Berry and Caroline Packer Berry. George Berry attended the Hill School in Pottstown, Pennsylvania, and received his B.A. degree with highest honors from Princeton University in 1921. He was awarded the M.D. degree from Johns Hopkins School of Medicine in 1925. After training as a house officer at Hopkins, Berry was offered a position at the Rockefeller Institute for Medical Research in New York City. He

remained there until 1932 when he accepted the chairmanship of the Department of Bacteriology at the University of Rochester School of Medicine and Dentistry. In addition to the professorship in bacteriology, Berry was appointed associate professor of medicine in recognition of his major contributions in the area of infectious disease.

In 1924, George Packer Berry married Elizabeth L'Estrange Duncan of Wanganui, New Zealand, who unfortunately died two years later from a streptococcal infection superimposed on measles. A daughter from

that marriage, Caroline Elizabeth Laporte, now resides in New York. In 1969, Berry married Mariana Richardson Wilkinson, widow of Gerald Hugh Wilkinson. Today, Mrs. Mariana Berry continues to live in Princeton, New Jersey, where she and Berry first met.

George Packer Berry spent 17 years at Rochester, where he served as associate dean of the School of Medicine and Dentistry. Following that distinguished tenure, he was chosen by Harvard University president James B. Conant to succeed C. Sidney Burwell as dean of Harvard Medical School in 1949.

During his years at the Rockefeller Institute and at Rochester, Berry became recognized nationally for his achievements in the field of animal virology and immunology and he acquired a reputation as a teacher with extraordinary perceptual insight and delivery skills. His lectures at Rochester were extremely well received; he brought his compelling interest in infectious agents as persuasively to the faculty as to the medical and graduate students.

Between 1930 and 1949, Berry was a vigorous laboratory scientist, collaborating at the Rockefeller Institute and at Rochester with such well-known figures as Richard E. Shope, Thomas M. Rivers, Cornelius P. Rhoads, and Jerome T. Syverton. He accomplished a series of studies on the virus of yellow fever, western equine encephalomyelitis virus, the psittacosis agent, the virus of myxomatosis, and the rabbit fibroma virus (also known as the Shope papilloma virus).

The range of Berry's research interests encompassed bacteriophages, x-ray inactivation of viruses, and several bacterial diseases, including Weil's disease and gonorrhea, caused by the gonococcus. His extensive studies of psittacosis had a major personal consequence—he contracted the disease and suffered some chronic sequelae.

The Shope papilloma virus and the related myxoma or myxomatosis virus of rabbits provided Berry with his most interesting series of experiments and a phenomenon that came to be known as the Berry-Dedrick transformation. He showed that the fibroma virus, which causes benign warts in the domestic rabbit, was closely related antigenically to the myxoma virus which causes a severe and deadly systemic disease in the same animals. Berry uncovered evi-







*George Packer Berry as child, serviceman, student, sailor, father.  
Facing page: with wife Mariana at home*



dence that animals exposed sufficiently long to the fibroma virus were protected against subsequent myxoma infection.

The experiment that attracted most attention involved the double infection of the same animal with fibroma virus and heat-killed myxoma viruses which alone could not cause disease in the rabbits. The animals infected by the two agents died of myxoma infection. This result was heralded as the transformation of fibroma virus into myxoma virus by the nucleic acid of the dead myxoma virus. Years later, experiments established that the "heat-killed myxoma virus" was reactivated by an enzyme supplied by the fibroma virus.

Berry's personal commitment was to science, characterized by his extensive collaboration with Drs. Shope, Rivers, Rous, and Rhoads. These scientists talked by telephone to let each other in on their latest experimental findings, and they exchanged materials to further the efforts each was making in the same subject area. Berry's interest was in trying to unlock the secrets of nature more than in questing after personal glory, an attitude toward science from a bygone era. □

*Harold Amos, PhD, is Maude and Lillian Presley Professor of Microbiology and Molecular Genetics at HMS.*

staff frequently borrowed. He badgered staff into criticizing his thoughts and then he challenged theirs.

Sunday afternoon before the opening lecture, I heard him pace around his laboratory, preparing for the big day. Monday morning, he arrived at 7:30 to check all the material on the boards, the slides, and the recording machine! Then he disappeared, and punctually, at eight a.m., he entered the lecture hall to begin his presentation. Staff and students had to attend each lecture and, when called on, all were expected to offer a critique.

Before I gave my first lecture, Berry reminded me that there would be one hundred students, and therefore the consumption of one hundred human-hours. Thus, it would be appropriate for me to spend at least one hundred hours preparing the lecture! He expected me to keep the same high standards he set for himself.

In the spring of '49, as dean Berry was preparing to leave for Harvard, he attended my preliminary examination and asked the concluding question: "Imagine yourself to be a chemist. How would you go about synthesizing a virus?" That question was typical of the quality of his probing and has given me food for thought ever since.

One of the best insights into dean Berry's character comes from a story about his journey to England. He had a reservation on one of the Queens. However, business at HMS delayed his departure from Boston, and he found himself on an early morning train to New York the day the boat was to sail.

Somewhere in Connecticut the train ground to a halt because of malfunction. It soon became evident that, if he remained on board, he would miss the boat. He took his bags, jumped off the train, removed the belt from his trousers to use as a sling for the bags, and was off across the fields until he found a farmhouse with a truck.

Somehow, dean Berry persuaded the farmer to drive this vehicle of uncertain reliability to New York, and, after considerable haggling over the fee, they arrived at the pier just as the gangplank started going up! Berry's determination, resourcefulness, and persuasive abilities were always astounding!

His sense of responsibility to his former students was touching. He remembered their experiment results and their personal goals. He kept in

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# FRIEND AND MENTOR

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by Charlotte Litt

**G**eorge Packer Berry entered my life in January of 1947. He interviewed me as a prospective graduate student in the Department of Bacteriology & Immunology at the University of Rochester Medical School.

The interview proceeded in what came to be a familiar pattern for our "official" conversations. First, I stated

for the oddballs." And so I became a graduate student in his department.

In recruiting medical students and faculty, Berry's gambling instincts paid off handsomely. He had an intuitive sense of the potential of unconventional individuals. His evaluation rested less on test scores and formal credentials than on that all-important personal interview.

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*Days before the beginning of his course, everyone in the department could feel electricity in the air.*

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the issue. "What do you want me to do about it?" he replied. Then, on hearing my response, he delivered the challenge: "If you were in my place, what would you decide, and why?"

In summarizing our first meeting he said, "You know, the fun of this job is to have the opportunity to gamble. Anyone can give a *phi beta kappa* a chance at a graduate education, but now and then one has to provide

As a teacher, Berry captivated his audience and conveyed vividly the excitement of pursuing knowledge beyond the normal boundaries of science, history, economics, and government. Days before the beginning of his introductory course, everyone in the department could feel electricity in the air. The professor was on the warpath, trying to find his private books and journals which the





*Clockwise from top left: modelling protective gear devised for study of psittacosis (parrot fever); with Tom Rivers at Rockefeller Institute; with Stanhope Bayne-Jones and Herbert Morgan '42.*

touch with them and revelled in their triumphs.

George Packer Berry was as much a friend as mentor. He was witness to our civil marriage ceremony, bringing a bottle of champagne from the cellar of a certain Miss Countway. One Saturday noon, when I was soaked from washing endless glassware, he dragged me from the lab saying, "Comb your hair, and I'll take you to the Harvard Club." We arrived at the club where he announced, "I'll come with you through the rear entrance; You can't enter the front lobby." That was how George Berry dealt with sex discrimination!

When we were expecting our first child, he asked about the names we had chosen. Upon hearing some common, family-related names, he threw down a challenge: "I expect more originality from the Litts." This triggered a crisis; even in our personal lives we had to measure up to his standards. After considerable agonizing, we got the idea of throwing the letters of our names into a pool and recombining them into the name of our child. We came up with the name Timothe, ending with an "e", because our names lacked a "y". When dean Berry learned of the name and its recombinant origin, he accepted it, much to our relief.

After he retired to Princeton,

Berry's messages to us were full of joy for far too short a time. We visited him a few times after he fell ill, and each time, his interest in us, our growing family, and our work was as heartwarming as ever. His pleasure in our family's building project never ceased. He examined photographs in detail even if he needed a magnifying glass

to see. This link to the past brought back the twinkle in his eyes which I first noticed so many years ago on that fateful January day in 1947. □

*Charlotte Litt is consultant to the Division of Medical Sciences at HMS. She received her PhD from the University of Rochester in 1950.*

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## A PRINCETON SALUTE

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by Robert F. Goheen

Distinguished medical researcher, teacher, administrator, caring physician, dedicated public servant, attentive foundation and university trustee, ready counsellor of young and old—over the course of a long and fruitful life, George Packer Berry accomplished much, achieved positions of influence, and won many deserved honors.

Dedicated as he was to every task he laid his hand to, it can be said that nothing, after his own family, had greater claim on George Berry's affection and loyalty than Princeton University. As the son of George Titus

There followed eight years as a medical student, resident, and instructor of medicine at Johns Hopkins University, three years on a research appointment at the Rockefeller Institute, and 17 years as a professor of biology and bacteriology at the University of Rochester School of Medicine and Dentistry, where, in the later years, he also served as an associate dean. In 1949, George was called to what was arguably the most prestigious and influential administrative position in American medical education at the time—the deanship of the Harvard Medical School, where he served until 1965.

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*For Princetonians, George's accomplishment at Harvard became a matter of satisfaction and pride.*

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Berry, of the class of 1887, he came by that affection early. Preparation at the Hill School led him naturally to Princeton in the Class of 1921. As a sophomore here he came under the stimulating influence of Edwin Grant Conklin, a prominent biologist whom Woodrow Wilson had called to Princeton. Serving as professor Conklin's laboratory assistant during his junior and senior years, George went on to win election to *phi beta kappa* and graduated with highest honors in biology.

For Princetonians who followed his career, George's accomplishments at Harvard became matters of satisfaction and pride as he worked to create new professorships, draw distinguished investigators to the medical faculty, and accomplish the Herculean task of unifying the medical school and the teaching hospitals.

As dean, George kept four secretaries busy. He once said they taught him that he could run a medical school with just two words: "Yes, M'am." Less modestly, president







*Berry as teacher, dean, and scholar receiving honorary doctorate from Boston University.*

*Facing page: "Off to the wards!" rallies Berry with a flourish of the sword.*



Conant later described his appointment of George as "the best job I did on the administrative side while president of Harvard."

On the occasion of the thirteenth reunion of the Princeton class of 1921, dean Berry's classmates showed their respect by conferring on him the Class of 1921 Distinguished Service Award. A few days later, his university accorded him the degree of Doctor of Science, *honoris causa*.

George Berry was elected a charter trustee of Princeton University in 1956 and served actively in that role for the next 12 years. On his retirement from the board, it was my privilege to speak of the well-informed advice and vigorous concern that he had brought to its deliberations. Among other things, I said: "George is a patient and judicious listener, whose contributions to our discussions have always been lucid, forceful, compelling. He knows what a university is all about and what are the essential

ingredients for its selective growth to preserve excellence."

When Harvard's retirement age requirement caught up with George in 1965, no one who knew would have expected him to become inactive. Princeton was particularly fortunate to have him accept the president's invitation to return to his alma mater as a special consultant on the life sciences. In this capacity, not only did his uniquely broad professional experience and thoughtful insights prove invaluable to the university's admin-

istration, they were also unstintingly available to undergraduates considering medical careers. For George Berry, helping learners and serving his university went hand-in-hand. □

*Robert Goheen is former president of Princeton University (1957-1972). He is currently the director of Mellon Fellowships in the Humanities, senior fellow in public and international affairs at Princeton University's Woodrow Wilson School, and a trustee of American University of Beirut.*

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## DEAN WITH A DIFFERENCE

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by George Thorn

It is a privilege for me to be included in these memoirs of George Berry. I served under five deans of the medical school, and George Berry's deanship was one of the most distinguished. My relationship to Berry centered on his relationship to clinical departments, in particular, the Department of Medicine at the Brigham. Three vignettes stand out that illustrate the breadth

Brigham Hospital. In March of 1953 Wilhelm received Brigham Trustee approval of the dean's plan and made out-patient as well as in-patient beds in the Brigham available to students. He also generated space for the Harvard Medical Health Care Center within the Brigham. In April of 1953, Harvard University approved the plan and made possible the appointment of George Nichols as full-time direc-

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*Of greatest consequence was the "atomic bomb"  
Berry ignited when he suggested that six  
highly individualized hospitals join together  
as a conglomerate!*

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of interest and the administrative capacity of this great man.

In the early 1950s, Berry was concerned that the care of the large group of students on Shattuck Street was pretty much "hit or miss." It is true that the area abounded in outstanding physicians, but how students entered the health system, who cared for them, what happened on their return from office or hospital, was rarely coordinated.

Dean Berry initiated the following steps. First, he enlisted the support and collaboration of Norbert Wilhelm, director of the Peter

tor of health in the Shattuck Street area. From then on, Harvard has maintained an outstanding facility available to faculty as well as students in the medical school area.

Part of Berry's plan envisaged the collaboration of the School of Public Health in developing preventive medicine programs around this facility. The dean hoped that contact between students and faculty members in a patient-physician relationship would, in its own way, provide an additional and important educational experience.

After 1950, two problems in par-







*Clockwise from above: beside painting of himself; with Harvard president Nathan Pusey; at lunch with Walter Cannon; three HMS deans (Robert Ebert, Charles Sidney Burwell, and George Packer Berry); with Archibald MacLeish before architect's rendering of Countway Library. Facing page: the Flexner Teaching Award granted Berry in 1962.*

ticular troubled the dean. The first was the need for expanded postgraduate training for the large number of men and women returning from military service. A second was the well-known fact that the professional care given in our veterans' hospitals was less than optimal.

Berry tackled these problems with a relatively simple approach—he enlisted the medical school and the teaching hospitals in the care of patients at veterans' hospitals. This solution was presented to appropriate authorities and accepted. Thereupon, dean Berry appeared in my office one day and said, "George, would you be willing to include the West Roxbury Veterans' Hospital Medical Service in your department?"

My answer was simply, "Yes, I would be delighted, provided I can nominate the chief of the medical department." This was agreed on, and my nominee was Thomas Warthin '34. He accepted, and the manner in which he developed his service at West Roxbury was an excellent example to the country at large.

Of course, this increase in the number of patients meant doubling the Brigham house staff. The increase not only provided more training opportunities for medical students and house staff, but it provided a different population of patients which greatly

broadened house staff experience. The Medical-Surgical Services at West Roxbury have substantially improved the level of professional care veterans receive and have been a great source of pride to us at the Brigham.

Of greatest consequence, however, was the "atomic bomb" Berry ignited when he suggested that six highly individualized and independent Harvard-related hospitals join together as a conglomerate! Whereas the smaller hospitals were quite capable of giving excellent care in times past, the rapid technological developments in biomedical science made it impossible for each to staff itself fully over a wide range of emergency and service needs. The desirability of coordinated effort was obvious. Dean Berry suggested to the six hospital presidents that a planning committee be established with an "overview" committee and two subcommittees: a professional subcommittee consisting of all the chiefs-of-staff and a management subcommittee.

In 1961, the so-called Mission Group of the professional subcommittee, published its report. In June 1964, the plan had advanced to the point that Bertran Goldberg Associates were engaged as architects for the proposed hospital. Robert Glasser was appointed director of the project, but he resigned in 1965 to accept the deanship of Stanford University Medical School. Dean Berry resigned shortly thereafter and long tumultuous proceedings followed. Today, the magnificent new Brigham & Women's Hospital stands as a monument to a very daring, but sensible idea that only a strong, determined, astute dean could have initiated and supported over a long and trying period.

I have happy memories of the years I shared with George Packer Berry. □

*George W. Thorn is Hersey Professor of the Theory and Practice of Physics Emeritus. From 1942-72 he served as physician-in-chief at the Peter Bent Brigham Hospital.*

## POWERFUL ALLY

by Roy O. Greep

Obviously, I owe a great debt of gratitude to George Berry. My appointment as dean of the School of Dental Medicine, a position I held for 15 years, was clearly made at George's behest. In the days leading up to that event,

ogy, I must have been the ultimate in dark-horse candidates, my only claim to fame in the dental world being a mutant strain of rats that had no teeth.

On February 2, 1952, I was working in a makeshift laboratory in the

*It was characteristic of George to interject a note of humor, or even bring down the house with a newly acquired joke.*

rumors were afloat as to who might be appointed. Everyone in the school had a list of possible candidates, and, to my knowledge, my name was not on any of them. As a Ph.D. in zool-

anatomy building. Many will remember the situation in those days before Henry Meadow and his interflooring program—21 foot ceiling, tall, grimy window better left closed, creaky





floor, and gas, but no water. Quite adequate for a histologist. Along about mid-afternoon the phone rang; would I hold for dean Berry? "Oh God," I thought, "what have I done now?"

George was never one to beat around the bush. Without a word of preparation for the shock, he informed me that he and president Conant had decided that I fit the kind of person they were looking for for dean. He asked if I wanted to think it over. I told him that if I thought it over, I wouldn't accept and would probably live to regret it the rest of my life.

George was better acquainted with the problems in dental education than most medical people. He had been indoctrinated at Rochester through his acquaintance with George Eastman of Eastman Kodak and the Eastman Dental Clinic. At that time, the Eastman was America's leading institution in both dental research and clinical practice. George often talked about the Eastman, and I think it helped him formulate his own sound ideas as to what was needed at Harvard.

He took a lively interest in the School of Dental Medicine, attending and participating in our staff meetings. He was, by his own admission, envious of our informal ambience and free-wheeling discussions which sometimes reached the flash point with someone stomping out of the room. In these meetings, it was characteristic of George to interject a note of humor, or even to bring down the house with a newly acquired joke. (George traveled in high circles and often brought back jokes that were just plain good humor.)

Conant closed the doors on the old Harvard Dental School and opened what came to be a new era in dental medicine and dental education. George brought this act to completion by the sometimes painful process of enforcing new and upgraded academic standards and by making dentistry the branch of medicine it was originally intended to be by the founding fathers.

Naturally, I had some differences with George, mainly about money. What else would two deans be scraping about? At issue was Harvard's long-time policy that 'Each tub must

stand on its own bottom.' The School of Dental Medicine, a component of the Faculty of Medicine, was told to wait its turn at dipping into copious outside tills, but in my days that turn never came. Our squabbles in the counting house, though, have long since faded into history.

It is often said that spring comes in like a lion and goes out like a lamb. George came in like a lion and went out like a lion. The lion is king of the forest, and who can doubt that dean George Packer Berry reigned supreme over the Faculty of Medicine. The

lion's roar is menacing, but George did not have to raise his voice to ward off any challenge to his position, which was always one of strength.

For all the good things George did for the School of Dental Medicine, and for me personally, I sadly bid him a fond farewell. □

*Roy Greep, PhD, holds three emeritus titles: professor of Anatomy, John Rock Professor of Population Studies at the School of Public Health, and director of Laboratory of Human Reproduction and Reproductive Biology.*

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## HUMANIST CONVICTIONS

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by Lester Grant

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As a student at Harvard College and at HMS in the '50s, I served as one of dean George Packer Berry's assistants charged with mobilizing information about the school and its role in teaching medicine.

I came to know the dean as a highly articulate spokesman for the profession and a person with deep convictions concerning the humanist roots of medicine. He passed a good deal of his waking life wondering silently, and aloud, how to infuse medical students with a caring, concerned attitude toward patients, without chipping away at time needed for the study of hard biological science.

Dean Berry knew that enormous advances in basic science research brought increasing curricular constraint, overstuffed schedules, and diminishing student time for thoughtful interchanges with patients. He asked himself whether it would take more curricular time to teach students to be concerned about human needs. Was it even possible for medical schools to teach morality, or did students come by this through deeper channels—familial, social, environmental—more or less unchangeable by the age of 22?

Berry spoke to these points often, once in print in 1953:

"... Our preoccupation with scientific medicine has tended to let the patient fade into a faceless, nebulous creature, often no more than a number on a test tube or an entry on a chart. Such an attitude is not consistent with the best medicine. Moreover, it is not 'scientific.' While the student is learning a great deal about the patient's 17-ketosteroids, undeniably important, he tends to overlook the patient's anxieties and hatreds, his attitudes in his family setting and the pressures that hem him in. These, too, are important... scientific medicine is a misnomer. I think, when it is excessively preoccupied with the physical and chemical constitution."

This statement was made in an extension of Berry's presidential address before the Association of American Medical Colleges and appeared subsequently in the *Journal of Medical Education*. In helping Berry develop this monograph, I came to know him well. We spent weeks laboring over it, readjusting emphasis, source material, and syntax.

Berry had difficulty staring at a blank piece of paper and getting words on it, but he could sit and tell you what he had in mind to say. Transcribed, it came out just fine. With

*Facing page: pitching in during the heavy March 1960 snowstorm.*

sentences written out in front of him, Berry would attack them with relish, recasting them, invariably with improvement. Working with him was an exercise in exegesis: we had a new

ware of the myriad human associations swirling around him. He was shy. More than one person said that the closer one got to him, the shyer he seemed. I found him, while often

*Berry stood fast in hot and heavy interchanges with some highly articulate, indignant professors.*

manuscript each week, and then it was rewritten with additional interpolations.

Dean Berry was often preoccupied, musing quietly in his office, or in the corridors, about the ways of the world. He sometimes gave the impression of being aloof and una-

reserved, at other times expansive and even ebullient. Students did not come swarming to his door to seek his personal counsel, but when they did meet with him, privately or in groups, they found him a good listener and a caring person.

This caring side of Berry's per-

sonality was etched in my memory through one incident in particular. In a pre-graduation rumpus at Vanderbilt Hall, members of the senior class started a bonfire on the newly refurbished tennis courts, creating a noisy conflagration that brought complaints from Lying-In Hospital and a sizable bill for repair. The faculty was livid, fighting mad. There was sentiment to expel the eight or so students identified as instigators, or to withhold degrees for some indeterminate period, cancel internship appointments, or make them do penance in some remote area of Purgatory—Scollay Square, for example.

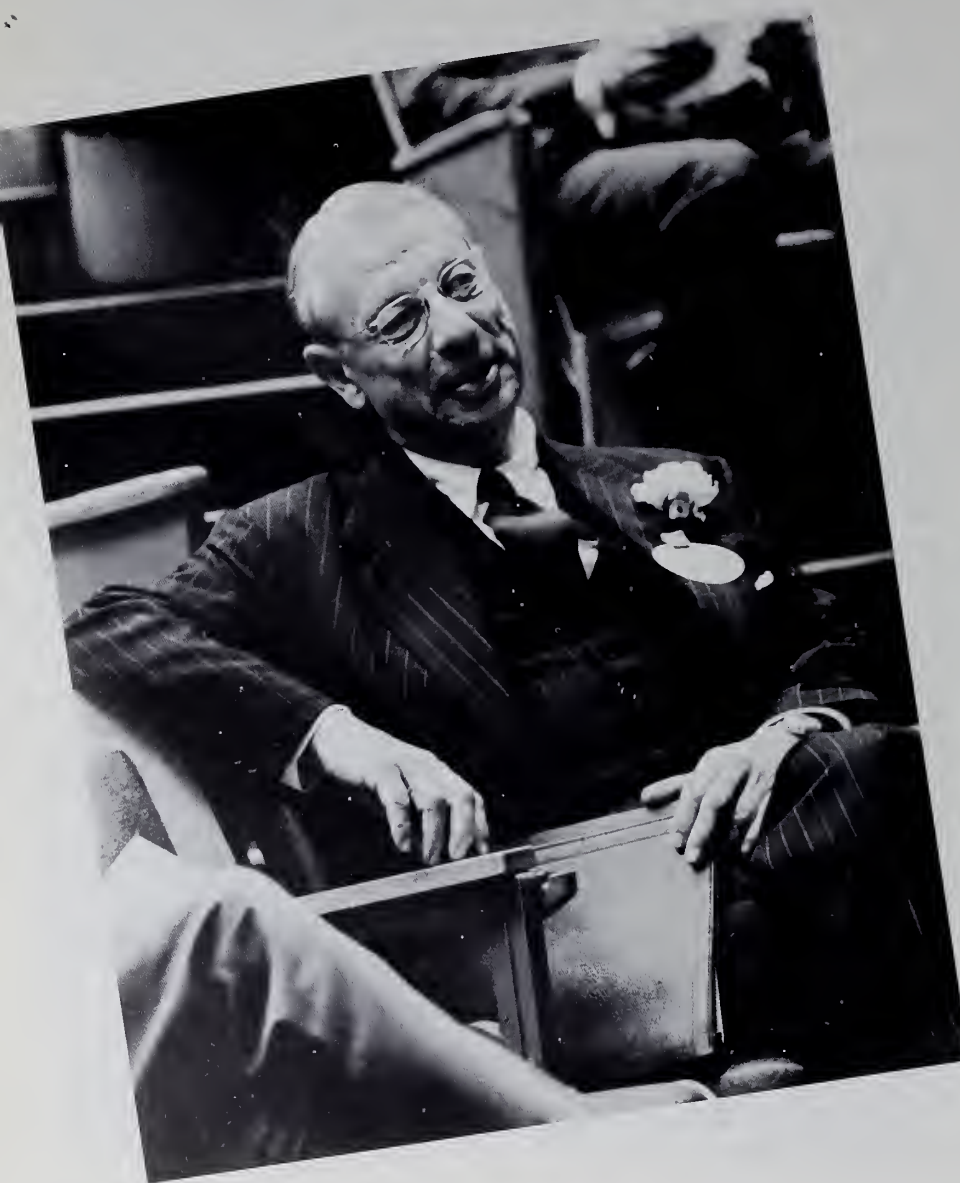
With a choleric faculty pulling thunder out of the skies, the dean could see that, in the heat of the battle, things might get out of control. Berry didn't want to condone hooliganism, but he also did not want the students decapitated. He stood fast in hot and heavy interchanges with some highly articulate, indignant professors. He got an agreement with the students on the cost of repairs, and graduation proceeded according to plan.

As a dean, George Berry was a bright and thoughtful academician who worked through his professional goals against the rich texture of a classical Princeton experience. He revitalized medical education at a time when it was undergoing severe institutional stress.

The teaching institutes which Berry created under the sponsorship of the AAMC were a major intellectual triumph. [Julius Richmond discusses these in more detail elsewhere in this issue.] A second monument of his tenure as dean, one he infused with boundless energy and organizational skill, was the evolution and flowering of Countway Library. Today, the Countway Library is witness to the rich resources of the Harvard Medical School.

Finally, Berry fought Harvard's research battles with the Feds. At one point, he convinced Washington that indirect research costs had to run in the range of 15 percent or his faculty would seriously consider dropping all federal funding! It was more than an idle gesture. He won his point, not only for Harvard but for all other medical schools as well. □

*Lester Grant '55 is a fellow in pathology (visiting professor) at St. Jude Children's Research Hospital in Memphis, Tennessee.*





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# PATHSETTER IN NATIONAL PEDAGOGY

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by Julius Richmond

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I was a young professor of pediatrics at a state university at the time I first knew dean George Packer Berry. He was responsible for my involvement in many national committees on medical education, and from the vantage of a young faculty member, I can identify a few characteristics of this charismatic dean.

First was his remarkable intellectual curiosity and vigor. Everything was grist for his mill. His fierce defense of the autonomy of scientists stemmed from his own excellent background in the field.

Second was Berry's prodigious work capacity. To the dismay of we faculty members who had young children at home, he insisted that many of his national committee meetings be held on weekends so that they would not intrude on his day-to-day responsibilities. But he never asked anyone to work harder than he did himself.

Third was his sense of humor which, combined with an infectious enthusiasm and ebullience, created a remarkable *esprit de corps* among the people he recruited to work for him. His enthusiasm in pursuing his campaigns led to numerous and lengthy letters, especially to Dr. Darley, president of the Association of American Medical Colleges, who once remarked that he wished he could steal Dr. Berry's typewriter.

Dean Berry really cared about the quality of medical education and was never self-conscious or apologetic about it. He never tired of pointing out that teaching and training were different. Statements about the "training" of the medical student offered him an opportunity to expound on the importance of medical "education". In a similar vein, he corrected any reference to medical education as "undergraduate". He also insisted that in matters of research and teaching he was a "unitarian"—the two had

to go hand-in-hand. (He never tired of explaining that this was part of the greatness of American medical education in contrast with European patterns in which research was dominant.)

Although Berry's leadership role in medical education at Harvard is well known, his role as a national leader in medical education may not be recognized as well. Lest he be a 'prophet not without honor, save in his own country', I will record my observations on his considerable national impact.

The Association of American Medical Colleges was the vehicle for Berry's national leadership. He saw in the AAMC the opportunity to mobilize the national community to improve the quality of medical education, and he was an opportunist in the best sense of the word. That organization had been moribund for years, and it performed even caretaking functions poorly; others of lesser insight would have written it off. In the years following World War II, Berry recognized that the AAMC could help medical centers throughout the country through a period of unprecedented expansion.

On assuming the presidency of the AAMC in 1951, Berry charted the course for a series of 'teaching institutes' which were to become the dominant activity of the association for the next decade. Berry dominated these teaching institutes and enhanced their productivity by lending them a continuity of theme and purpose. The reports of the institutes remain valuable to this day as repositories of data and wisdom on all aspects of medical education.

There were many enduring effects of Berry's national activities. Certainly, he generated 'consciousness raising' about the quality of teaching in our medical schools. This was particularly important at a time when funding for research was increasing.

The liberal tone of the teaching institutes, their openness, and their emphasis on new, creative approaches provided a national climate of flexibility and innovation in curriculum development and teaching. The teaching institutes created a hospitable environment for change in medical education.

In the national forum, Berry stimulated a generation of bright, young medical educators whose influence went far beyond the institutes. Part of Berry's social strategy was to provide a platform for talented young people. This was no happenstance; he had collected a bank of names. When institutes were planned and an appropriate mix of participants (by geography, specialty, or age) was sought, Berry would whip out his little black book and suggest candidates.

Through the institutes, medical education gained visibility and respect. University presidents became aware that medical educators were more self-critical and sophisticated about education than their counterparts from the other graduate or professional schools. In the preparation which preceded each institute, data was collected, papers were written, and the AAMC studies on the characteristics of medical students were undertaken.

The institutes were interdisciplinary in order to accommodate the views of significant figures outside of medicine. Harvard economist Seymour Harris, New York University philosopher Sidney Hook, Columbia sociologist Robert Merton, and the president of Cal Tech, Lee DuBridge, were but a few of the luminaries who enriched discussions at the institutes. Berry orchestrated all this in ways that seemed effortless.

For his outstanding leadership, the AAMC, in 1962, conferred on Berry the highest honor in medical education—The Abraham Flexner Award for Distinguished Service to Medical Education. The symbolic nature of this award is significant. It is fair to say that no one since Abraham Flexner himself has had so enduring an impact on improving the quality of medical education as George Packer Berry. □

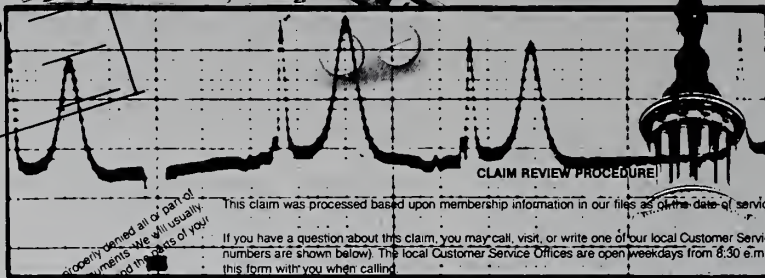
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*Julius Richmond, MD, is director of the Division of Health Policy Research and Education, and John D. MacArthur Professor of Health Policy. He served as U.S. Surgeon General and Assistant Secretary for Health from 1977-81.*



# MEDICAL

- 9028 ☐ Initial Office Visit
- 9026 ☐ Routine Follow-up Visit
- 9026 ☒ Extended Office Visit
- 9153 ☐ Emergency (Mon., weekend)
- 9153 ☐ Hospital or Nurs. Home
- 9153 ☐ Consult - extensive
- 9150 ☐ Hospital or Nurs. Home
- 9150 ☐ Consult - limited



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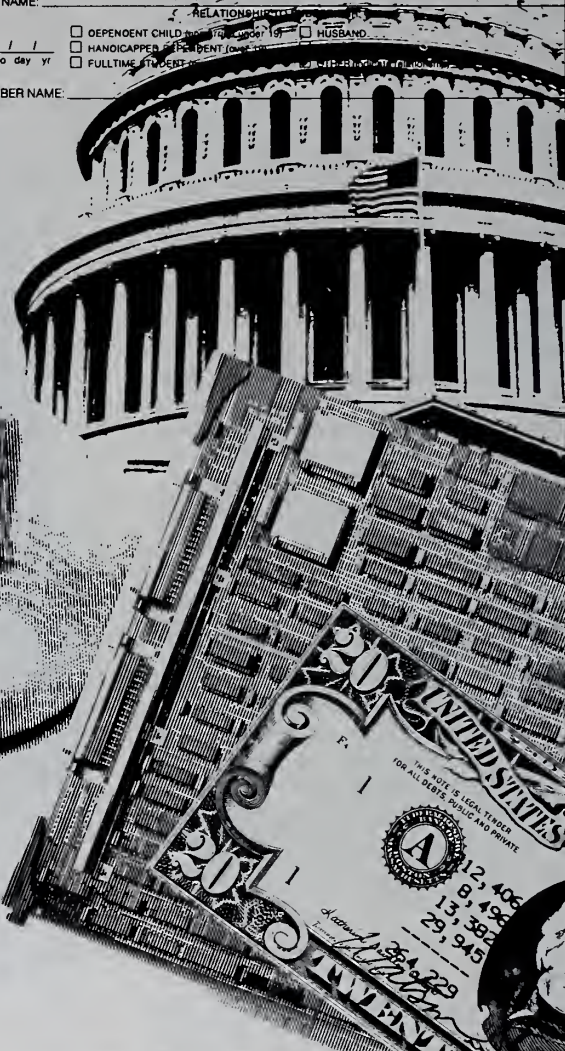
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- ☐ HUSBAND
- ☐ HANDICAPPED (dependent on you)
- ☐ FULLTIME STUDENT

CORRECT SUBSCRIBER NAME: \_\_\_\_\_

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MEDICINE AND SURGERY



Medicine



# 2000

## Health Care in the Year

*The following three essays have been transcribed from the spoken word. Two of the three were culled from the galaxy of symposia that graced Harvard's 350th celebration last September. Both look to the future. The authors, Mitchell Rabkin '55 and Gordon Moore '63 have edited their transcribed remarks to conform with the printed page. Mitchell Rabkin is president of Boston's Beth Israel Hospital and professor of medicine at HMS. Gordon Moore is director of Teaching Programs at the Harvard Community Health Plan and director of the New Pathway Project in General Medical Education at the school. The third essay is Francis H. Burr's "farewell address" to the Massachusetts General Hospital staff. It bears on the experience and opinions of hospital staffs everywhere. Burr was a member of the Harvard Corporation from 1954 to 1982, chairman of the Board of Trustees at M.G.H., and a partner in the law firm of Ropes and Gray. He shares his thoughts on where we are now and how we got here as a basis for forecasting the future of medicine.*

## Passing the Pursestrings: the Economic Powers To Be

by Mitchell T. Rabkin

**M**uch of the economic power once vested in physicians has now moved to the employers and the insurers who pay for care—Medicare, Medicaid, and business. These have become both the allocators and the rationers of revenue. How did this happen?

With Medicare and Medicaid budgets rising, federal and state governments have come to recognize that

the intrinsically inflationary cost reimbursement and fee-for-service systems cannot go on forever. American business scrutinized its dwindling bottom line during the recession of the early '80s, and realized that its health care payments had become large enough to be devoted the same diligence as its other costs.

Once it paid attention to these costs, American business learned that

it purchased enough health care to have real buying power. When the Washington Business Group on Health formed, and the top few of the Forbes 500 realized they were paying for the care of 50 million Americans, they began to sit in the driver's seat. With the present and projected surfeit of hospital beds and physicians, business and government both became positioned to consolidate their new hold.

What impact has this dominance of the payer had on the care of patients? With what consequences can this new locus of economic power influence clinical practice?

Payer activism was in part provoked by the comparison of utilization data from HMOs, such as Kaiser-Permanente, to that from conventional fee-for-service practice. The hospitalization rate of HMOs was about half that of the conventional with no difference in indices of health. Other studies, such as those of Wennberg, revealed dramatically differing rates of elective surgery in comparable communities, related not primarily to pathology but to availability of surgeons. Such variations led to the growing suspicion among government and business that doctor doesn't always know best, and justified to these payers their escalation of control.

The nationwide decline in length of hospital stay in recent years illustrates the force of the payers' economic power. The significant regional variation in length of hospital stay—as much as 1.5 days difference for comparable patients on the West vs. the East Coast—has prompted physicians to reexamine long-held assumptions about “proper” duration of stay. Beyond regional change, however, hospitalization has become abbreviated across the country. The trigger for this was economic, and it was pulled by the payers.

Whether these external pressures will ultimately oblige doctors and hospitals to go beyond their own best clinical judgments, in terms of length

of stay or criteria for admission or discharge, remains to be seen. I doubt physicians will be co-opted to the detriment of their patients, but already there is the portent of inconvenience and occasional distress among Medicare patients whisked through and out of the hospital under the stimulus of rules concerned more with money than medicine.

The shift of power from physician to payer has led not only to changes in the nature of care rendered, it threatens access to care for the poor. The cost-shifting that supports charity care is no longer tolerated by the payers' auditors. Once deemed a social good, health care now threatens to become a market commodity divided into two classes of care: one for the “haves” and one for the “have nots.” This is the very situation Medicare, Medicaid, and broadly applied health insurance for the working family were designed to eliminate.

If the mission of the hospital—the provision of care—is a public good, those who empower it should have public accountability. In the past, society relied upon the professionalism of the physician to guide the allocation of resources of care. Now, with the shift of revenue control to business and government, both with multiple priorities, direct accountability to the public is distanced. Will health care suffer as a result?

**H**ow are the new economics reshaping the character of the hospital? Today, as patients are admitted, the projected length of stay is entered into a system of “utilization review” under which the patient's stay is monitored. The benefits of such scrutiny can include more efficient scheduling of complex tests and more timely processing of applications for anticipated nursing home placement. More problematic are the pressures of an assigned average length of stay. It has become increasingly common for hospital discharge to take place

prematurely, in terms of the patient and family's understanding of the disease and how to care for it. Hospital discharge commonly occurs before the physician has a good feeling for how well the patient will manage overall.

It is most evident in the teaching hospital, but apparent in all institutions, that shortened stay results in an overall increase in the average intensity of illness in the hospital. This creates added demands on medical, nursing, and other staff not readily reflected in conventional patient-day statistics. For example, many patients today come to surgery on the same day of their admission. They arrive at the hospital early in the morning, move from a staging area directly into the operating suite, and after surgery, into the recovery room. Once the effects of anaesthesia have sufficiently worn off, patients are moved to their nursing care units for the remainder of the hospital stay.

There is limited time for the anaesthesia staff to get to know the patient before surgery and for the patient to be reassured about the experience he or she is facing. A problem also exists for nursing—the patient may spend several days recovering from surgery on a unit where both personnel and facilities are completely unfamiliar. In such circumstances, it is more of a struggle for staff to achieve the personalization that optimizes care. Such foreshortening creates a similar hurdle for the intern or resident, indeed for all staff who provide care during hospitalization.

In the teaching hospital, these pressures also create barriers to learning. The medical student is placed on a patient unit to gain familiarity with the natural history of illness. As hospital stay is truncated, the quality of the learning experience is undermined.

Not long ago, a medical student would have had the opportunity to take a history and perform a physical examination on an incoming patient. The student could reach tentative conclusions which might be shared later the same day with the senior physician, interns, and residents. The student's evening might include studying about the patient's disease, the nature of the surgery planned, the course to expect, and possible problems to look for. The student might scrub at surgery the following day and follow the patient for several more days. In this way, the student might learn how the expected physiological developments

**Health care threatens to become a divided commodity:**

**one class for the “haves” and one for the “have nots.”**



might be shaped by the individuality of that particular patient, an individuality the student had become cognizant of before the surgery itself.

Disease is an experiment of nature. The capable physician must make many observations to understand both its causative agent and the individual in whom it is acting.

By contrast, the first contact today's student might have with the patient is with the already anaesthetized and fully draped figure in the operating room—little more than a rectangle of exposed skin surrounded by sterile drapes. As the patient comes out of anaesthesia, the first verbal exchanges between student and patient are minimal, and there is precious little background for the student to evaluate that exquisite individuality of a patient struggling with disease. Often, for "efficiency," the patient has been admitted with diagnostic tests already scheduled and specific consultations already requested. Surely, these preordained decisions alter the educational experience for residents and medical students alike.

Increasingly the payer decides which hospitals to deal with and which not to. A hospital still works to retain the loyalty of its physicians so they do not admit patients elsewhere, but the doctors' cachet of unopposable dominance has disappeared. If a physician, for example, commit more dollars than third parties will pay for in the care of a patient, both the hospital and fellow physicians may no longer find that physician as congenial a colleague. That physician is losing money for the hospital, dissipating what economic gains may have been achieved through the prudent behavior of others. His contribution to filling hospital beds has lost its economic basis.

Furthermore, since capitated payments are increasingly the mode—payment of a fixed amount for a full year of medical care as opposed to fee-for-service arrangements—the "loyalty" of a physician must now extend to handling patients within the rules negotiated between the hospital and the payer. One goal of such arrangements is to keep the patient out of the hospital. The committed physician and hospital must side with that directive within the limits of clinical judgment. Thus, payment modalities have changed, the hegemony of the physician in the hospital has eroded (even though clinical authority remains), and the traditional hospital goals of full-bed occupancy

**The first contact today's student might have with a patient is with an already anaesthetized and fully draped figure—little more than a rectangle of exposed skin.**

and greater utilization have become qualified by the new economics of payment.

The ascendancy of third-party payers has also had a profound impact on the roles of trustees and hospital administrators. Governance behavior of hospital trustees has at times been inconsistent with responsible behavior in their own businesses. Under cost reimbursement, they have often sanctioned generous hospital spending just as government and third-party payers did. Because the health care premiums they pay as employers are determined in no small measure by the expenditures they sanction as hospital trustees, trustees now are developing more rigorous standards of performance for hospitals, for themselves, and for health care systems overall. There are new requirements of accountability for administrators and new standards of prudent economic behavior for physicians.

The nature of hospital management is also changing. With cost reimbursement no longer the mode, sound business performance has become a requirement. Sophisticated payers no longer write checks in the amount of the hospital's charges. They negotiate for discounts, which necessitate sharp cost accounting and sophisticated strategic planning by hospital management. No longer is the hospital administrator simply running a doctor's workshop where, if Blue Cross and other payers don't happen to come up with the dollars, generous trustees make up the difference.

Hospitals have become a complex big business, and management decisions can make the difference between the life and death of an institution. As a result, the training of hospital administrators has become oriented to business and management, instead of health policy and public health. Standards of performance for hospital administrators are rising, and trust-

tees are not hesitant to make personnel changes on the basis of business performance. Within the hospital, physicians' voices still have power and can still undo the tenure of administrators. But trustees must juxtapose such physician dissatisfaction with the economic realpolitik of hospital operations. The clinical and personal judgments of physicians are also being increasingly brought into the management matrix.

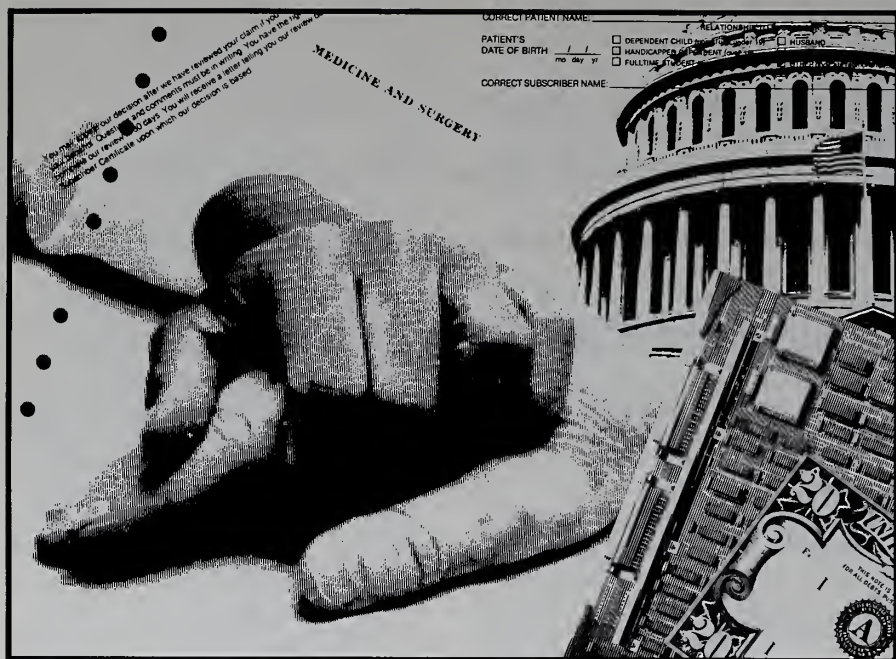
As a result of external, primarily economic, forces the basic power to generate revenue for the hospital has shifted from doctor to payer. The roles of doctor, patient, administrator, and trustee have evolved, even while the basic nature of the hospital continues unaltered—that of nurturing a class of infirm individuals.

In the complexity that is the hospital, a forgiving and inflationary system of payment led to the escalation of costs, which have become intolerable. Dramatic changes have followed, with a struggle now underway to find a balance between quality and economic viability, from the viewpoints of the patient, practitioner, payer, and society.

New roles and relationships, new pressures and stresses are being visited upon patients, professionals, hospitals, trustees, and their communities. Understanding better the events that have brought about these changes should help us forge more workable solutions for the future.

For many decades, Harvard's contribution has been an important one, from adding to the store of fundamental knowledge about illness and health—wherein lies the greatest economy—to issues of economic and public policy, ethics of patient care, and the perspectives of public health. For us at the university, it is a privilege to be a small part of this sweep of history, and to have the opportunity to try to better the health of the nation and the world. □





# Cost Shock: Back to the Future of Patient Care

by Gordon T. Moore

**W**e are in the middle of a molecular, biologic revolution that is causing a profound change in the way we understand disease, and how we produce new techniques for its treatment. The change is comparable to going from the engine room to the bridge of a ship; we're entering the control room of disease. Change is happening now, and it's going to accelerate in the future.

In the year 2000, we will have a better understanding of why diseases occur and a more targeted approach to treatment than we have now. With genetic manipulation, we will produce drugs in a focused and inexpensive way. These changes should decrease rather than increase the cost of medical care.

If we looked up diabetes mellitus in a Merck Manual at the turn of the century, we would have found about 80 different treatments, from turpentine stoops to flax seed poultices. We didn't know very much about diabetes then, but when the defect was identified and insulin discovered, its treatment became rational, and multiple theories became one. When I

began my house officer training in 1963, there was a storage room filled with iron lungs on the top floor of MGH's White Building. A whole technology was wiped out in the span of a year or two after the last great polio epidemic in the 1950s. A new understanding of polio and its management allowed us to intervene so effectively that it eliminated an entire industry. That will happen with AIDS and with cancer, probably before the turn of the century.

Because of this, it is a safe assumption that properly applied technology is not just a cost-increasing force but can be cost-reducing. It is technology applied to disease where it doesn't belong that creates much of the cost overrun. Using high technology for chronic, degenerative diseases increases costs with limited benefit, while the same technology may have dramatic effect in certain diseases where it yields clear diagnosis and effective treatment. Physicians will be pressured to apply biotechnology appropriately in the competitive, cost-constrained environment in which we will increasingly find ourselves working.

Although information technology has been around a long time, it has had very little impact on the medical care physicians deliver. We're on the edge of a breakthrough in this area, not because medicine is going to discover things through the application of computers, but because medicine is based on information management, its retrieval, and use. We live in the 19th century in terms of our use of information in medicine.

Unused technologies that already exist will be applied by the year 2000. Today, a little carrying case the size of a pie plate can hold 10 years worth of the entire world's literature in English. Today, one can access the National Library of Medicine and instantly retrieve information that will be useful in patient care. Whole books are stored in computers, but we lack the ability to use this technology.

Our problem is that we don't have taxonomic structures or indexes to allow easy manipulation of this information. When we do, physicians will view the computer as an instrument as important as the stethoscope has been during the last century. Physicians will then have immediate access to the expert knowledge of specialists.

Although I'm not sanguine about having machines think for doctors—artificial intelligence—medicine is a field in which computers can be helpful for specific types of decision-making. Doctors must generate an array of possibilities for the cause of a patient's problem and then narrow these by testing how well they fit the symptoms and diagnostic findings. This has been labeled "hypothetico-deductive thinking." Computers can provide a rich and accurate array of possibilities for each given set of information about the patient.

Computers can also help physicians make decisions about appropriate drugs and tests. These capabilities, coupled to a system that makes the computer easily accessible to the physician, will improve the quality of care and create more time for physicians to do other things.

**C**ost is the dominant issue that will affect medical care in the future. When we speak about reducing the cost of medical care, we are really talking about reducing the expense to the third-party payers. Government and business have been the major providers of the revenue that has fueled medical care in this country. There is little question that they have decided



**It is a societal, adolescent fantasy that we  
can keep people alive forever.**

to put a cap on their costs, and will make every effort to transfer costs to the consumer.

This does not necessarily mean that the cost of medical care will be 10, 12, or an even higher percentage of the GNP in the year 2000. It will depend on what people wish to buy and whether medical care competes with other uses of discretionary income, such as second homes and extra automobiles.

There are two ways we may see these costs managed by the year 2000. First, businesses may limit what they spend by moving to self-insurance if they have a better than average risk employee population. This "unbundling" of the insurance market would undermine the traditional role of health insurance in pooling risk and providing coverage for all. We would see a new population of under-insured people emerge in industries with older or socially disadvantaged employees. These companies would see their health insurance rise as low risks leave the insurance pool. Their response might be to cap their contributions and transfer costs to their employees.

Secondly, the government will probably succeed in reducing its contribution to the medical care of the poor and elderly, although it is unlikely they'll completely pull all financial support. Whether by regulating the providers of care or by restricting what is covered, the costs of care will increasingly be shifted away from government.

This ceiling on third-party payment will most likely lead to a three-tiered system of health care. One system, providing payment for only the most basic services, will be financed by a patchwork of government and industry-sponsored insurance. It will provide limited coverage for the uninsured poor and near poor, and for under-insured workers in industries unable to afford comprehensive coverage. For this group, con-

ditions such as pneumonia will likely be covered, but not organ transplantation.

There will be a second, very large group of Americans who will receive their care through managed health care systems. The third parties will purchase, and these systems will provide, a package of services for a fixed price, negotiated in advance. Within this sector, competition will be tremendous for the provision and purchase of the lowest cost, most comprehensive, and highest quality package of services. Benefits will be relatively comprehensive but very tightly managed by the insurers and providers of care.

Last of all, there will be a new "luxury market." The combination of an oversupply of physicians, limitations of payment and choice within basic insurance coverage, and available discretionary income will lead to a new entrepreneurialism in medicine. Many physicians, given limited incomes and restricted work opportunities, will invent new services to offer. They will provide these services for a luxury market dissatisfied with the limitations of the managed health care system.

There will be inventions that will strain our credulity. Physicians may develop "wellness" centers providing preventive health services, work in health clubs, join foreign travel clubs as resident physicians, and may provide 24-hour-a-day home visits as well as other management for home-bound patients.

The new entrepreneurialism and changes in the delivery and financing of medical care will reveal a side of the profession carefully protected in the past—its "for-profit" aspects. While physicians have almost always worked for profit, until now they have earned their money largely by providing or ordering medical services for their patients, services which were generally paid for by others.

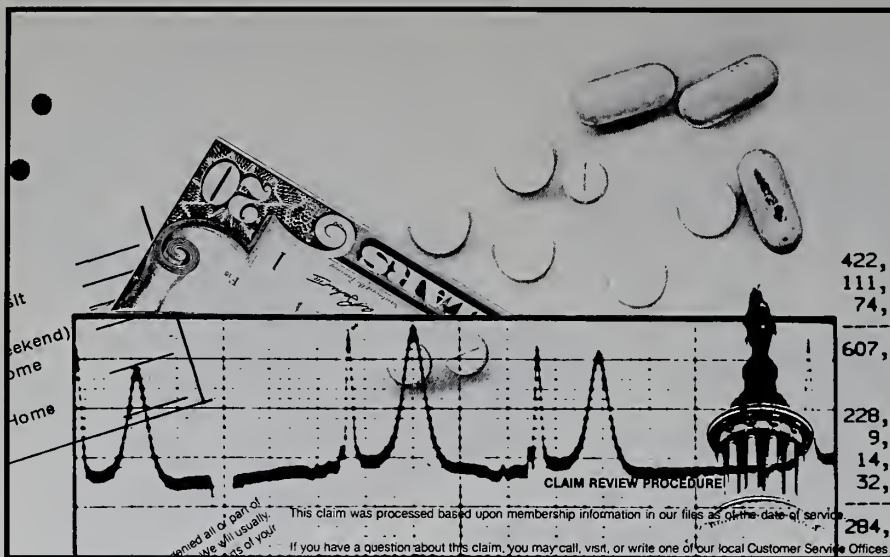
As physicians work to create demand for new services that are less clearly related to the direct care of illness, they run the risk of being viewed as businessmen providing products in health care. Moreover, a growing number of companies organized to provide medical care services are operating as "for-profits." The increasing focus on the business of medicine is likely to diminish public respect for the profession.

Of even greater concern for the future is the direct conflict that physicians may have with their patients' interests. Many health insurance and delivery organizations have recognized that physicians must be involved in the allocational decisions that allow costs to be reduced. In this country, in contrast to Great Britain, physicians will be required to participate in external quality review procedures that protect the interests of the patient. No longer will quality assurance be left solely to the profession.

Finally we come to aging. By the year 2000, technology will be doing a better job at treating diseases, but the number of treatable diseases for which technology is applicable will have gone down. As the population ages, treatable diseases will be replaced by chronic diseases of a degenerative nature that we cannot treat adequately. It's a societal, adolescent fantasy that we can keep people alive forever. Ideologically, we believe in the technology "fix," but there will be little appropriate application of our many technologies to this country's most extensive, residual diseases.

For the first time in 20 or 30 years, physicians will have to learn to live within the limitations of scarce resources and inadequate and ineffective technologies. Physicians will rediscover something they did 50 years ago. They will care for the patient. They will be empathetic. They will learn that the greatest thing you can do for somebody with a chronic disease is to be there as a fellow human being.

We will learn to talk with patients again instead of simply pushing machines and instruments at them. Physicians will rediscover, in a technological decade, that a large part of what they do is caring, and helping people adjust to the inevitable limitations of their lives. I welcome that. It will be a very exciting era for physicians, and it will revive the doctor-patient relationships that have made medicine the queen of the professions. □



# Necessary Distractions: Malpractice, For-profits, and Measuring Quality of Care

by Francis H. Burr

I am a layman without a professional or scholarly understanding of health care. The most I can hope to attain is what my friend Henry Rosovsky calls "executive understanding." I console myself that this is better than no understanding at all, and that Alexander Pope was wrong when he said "a little learning is a dangerous thing."

I'll start with malpractice. I regret there is very little in this area that is positive. I have been a director of CRICO, your malpractice insurer, ever since it was founded. Harvard lent us the money to establish the financial reserves necessary to get started. Our sole purpose was, and is, to provide malpractice insurance for doctors and hospitals in the Harvard system at the cheapest possible rate consistent with sound actuarial practice. So far we have been successful, although costs have been escalating. There is no such thing as certainty, but I am confident our enterprise is financially sound.

That's the good news, and that's about the only good news. The latest Massachusetts legislation labelled malpractice reform is nothing of the kind. It has a few good provisions

but, on balance, makes a bad situation worse. The malpractice plaintiff's bar is delighted with it, and anything that delights them is by definition a scourge on the rest of humanity.

There is a thoroughly understandable temptation to blame defendants' lawyers when something goes wrong, particularly when there is an unjustified and unreasonable verdict against the doctor. Occasionally the lawyer has not done a good job. If not, we want to know about it. We are deeply, even passionately, committed to stemming the tide of malpractice cases.

After all, the Constitution of the United States does not guarantee justice. It merely guarantees trial by jury. Every once in a while the system of justice administered in the courts gets seriously out of whack in particular areas. The two major areas today are malpractice and product liability.

There are a number of steps that could help restore this imbalance, but they will require legislation. Unfortunately the legislatures, both state and federal, consist of very few doctors, very few businessmen, and a huge bolus of plaintiffs' lawyers. Nothing effective will be done unless the

public gets sufficiently aroused to demand it.

The most recent estimates I have seen are that less than 25 percent of the total costs associated with malpractice litigation wind up in the hands of injured parties. Often they end up with the wrong parties, and usually after a five- or six-year wait. How can anyone mount an intellectually viable defense of such a system?

In the meantime, as a headline in *Hospital Magazine* points out, "Joint Underwriting Associations Flirt With Disaster." The Massachusetts JUA is over \$604 million in the red. Any private insurance company in such a position would be forced to close its doors, leaving its insureds hanging in the wind. There is no way in God's earth they could charge enough premiums to make them solvent again. When this crisis finally forces the state government to action, the only solution will be to present taxpayers with a colossal bill, probably after first attempting to assess all the solvent insurers. To me this has a distinct aroma of unconstitutionality.

In the meantime we can take steps to control and manage risks and minimize liabilities. This will take time and effort, and detract from the time you would like to give to patient care and teaching. However, I see no escape.

My next topic has managed to stir up a lot of emotion in the past few years, and a lot of nonsense, as well as some sense, has been written about it: the debate about profit versus non-profit hospitals. Our sister institution, McLean Hospital, became directly involved in the controversy, and although it is not an active issue now, a number of people at MGH and HMS were drawn in.

What prompts me to talk about this now is an article entitled "Who Profits from Non-Profits" by Prof. Regina Herzlinger of Harvard, which will appear shortly in the *Harvard Business Review* [January/February 1987]. Herzlinger believes the delivery system will inevitably become for-profit (although she excludes the teaching hospitals from this prediction). Her *Business Review* article (and I have only seen a pre-publication draft) elaborates on and documents this thesis. She and her co-author take figures from both profit and non-profit chains for the years 1977 and 1981, perform a number of elaborate adjustments on them to make them compa-



nable, and then draw conclusions. Let me quote a few:

- "While non-profit hospitals receive more social subsidies than for-profits, they do not achieve better social results. They are not more accessible to the uninsured and medically indigent, nor do they price less aggressively. They are also more oriented toward short-term results, replacing plant and equipment much more slowly than for-profits."
- "Non-profits, however, do more to maximize the welfare of the physicians who are their main consumers. These hospitals make large numbers of staff and beds available to the physicians, and they finance these benefits through social subsidies, tax exemptions, and delays in replacing plant and equipment. Today's physicians are subsidized by current taxpayers and future patients."
- "For-profit hospitals, in contrast, produce better results for society and require virtually no societal investment to keep them afloat. They are more efficient than non-profits, reinvest their earnings in newer plant and equipment, and offer just as broad a range of services to a large number of patients, including the medically indigent."
- "Our data suggest that, at the very least, non-profit hospitals do not inevitably improve social welfare in their communities. Indeed, the hospital's professional staff—and not the patients or society—may be capturing many of the benefits inherent in the nonprofit form. This imbalance is unlikely to happen in a for-profit organization subject to stock market discipline."

I admit to considerable pleasure in having someone with impressive credentials join the ranks against such a formidable opponent as Bud [Dr. Arnold] Relman who, I believe, has been having it much too much his way. But I cannot and do not agree with many of Prof. Herzlinger's conclusions.

First, the attempt to develop comparable statistical models, while laudable, does not produce the conclusions she alleges. The for-profit chains may be, and probably are, typical of for-profits. I submit that non-profit chains are in no way typical of non-profits, although she states, without statistical support, "we believe our findings apply as much to today's hospitals as they do to hospital chains in the late 1970s." She states, for example, that the non-profits "are not more accessible to the uninsured and medically indigent."

She supports this statement as follows: "For-profits do not deny the poor

access to care. In fact, we found the for-profits gave slightly more access to patients who carry poor or no health insurance than did the non-profits. The reasons are straightforward: hospital costs are mostly fixed and the marginal costs of an additional patient day, generally low. Even an indigent patient contributes somewhat to covering the hospital's fixed costs."

Not in the MGH, they don't! Most of our indigents are not covered by any form of insurance and contribute nothing. She may be excluding teaching hospitals from her analysis, but these are the very non-profits that end up caring for most of the indigent patients.

Let me take another statement. "Non-profits are more oriented toward short-term results, replacing plant and equipment more slowly than for-profits," and do that "to maximize the welfare of the physicians" by financing the benefits of "large numbers of staff and beds" through "social subsidies, tax exemptions, and delays in replacing plant and equipment."

It is true that we have delayed in replacing plant, but not equipment. I never realized we had done this to maximize the welfare of the physicians. In fact I find the logic of that statement hard to understand. Remember that the non-profits are older and located in big cities and the Northeast, and the for-profits are new and largely in sun-belt areas. The latest date used in her survey is 1981, before DRGs and when the federal government was still happily including depreciation as a reimbursement cost. I could go on in somewhat the same vein, but it would be tedious to you and not convincing either to Prof. Herzlinger or Dr. Relman.

My own simplistic conclusion is that the whole debate is pointless and about to dry up and wither away. When the Bernstein survey told us that the whole health care system in the United States would wind up in the hands of a few gigantic for-profit corporations, it became very important to critically examine where we were heading. That projected scenario is simply not going to happen.

Profit has gone out of the general hospital business. The for-profits—while still deeply involved in HMOs, long term care, and specialized hospitals—are *disinvesting*, not *investing*, in general hospitals. As that very wise observer Bruce Vladek has pointed out: "When the air clears, the provision of inpatient hospital care

will be dominated, as it has been in the United States since the turn of the century, by voluntary-private, not-for-profit institutions. The future of American hospitals and the future of voluntary hospitals will be largely synonymous"—whatever that future is.

Let me turn now to the MGH. I thought fiscal year 1986 would be a crisis for us financially since the original budget projections put us more than \$10 million in the red. But thanks to hard work on everybody's part and a few breaks, we finished slightly in the black. Although very far from relaxed, and although I realize that anyone predicting what the state and federal legislatures and bureaucracies will do is feckless, I nevertheless believe that with the same hard work and dedication on everyone's part we will be able to manage this year as well.

I say this in spite of the fact that the proposed federal budget cuts six billion dollars out of Medicare and Medicaid, and in spite of the fact that this state is operating under chapter 574—in some respects the most difficult and unreasonable of all state legislation, particularly its revenue cap provisions. However, even if my cautious optimism comes true and we finish fiscal 1987 somewhere near in balance, I am convinced that we will never return to the days of milk and honey—reimbursement for reasonable cost. I believe that never again in our working lives will we see a health care system where cost is not a major consideration for everyone involved.

This is not necessarily bad. With the right emphasis, it will prevent waste and permit better use of our national and medical resources. But—and it is a very big but—we have got to see that the emphasis on cost does not come at the expense of quality. Here we run into a challenging and difficult problem that has yet to be solved. How do we explain, predict, and prove to the eager cost-cutters that a particular restriction or set of limitations will affect quality adversely?

We must develop far better statistical bases of analysis to produce some quantitative measures of quality that will stand up to attack. For example, what is the optimum length of stay for diagnosis X or procedure Y? How much leeway should patients have who live far from the hospital, and how do you write precise definitions for them without creating a set of regulations



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that will make the Internal Revenue Code look like a postcard by comparison? Will early discharge result in prolonged convalescence and delay return of the patient to the work force, a clearly uneconomical effect? Or will it result in readmission, which is even worse—and so on and so forth.

I do not underestimate the difficulties. I hope that the effort to force all treatment into a nationwide pattern of uniformity, particularly with respect to new methods of treatment, will collapse of its own weight. It has been wisely said that for all technology there is a period when the rate at which it is used is far higher in some geographic areas than others. Any effort to enforce average rates or to drive all areas toward low rates will work against the dissemination of new technologies no matter how beneficial or effective the reduction effort may be.

We are all acutely aware that there is a large subjective element to quality which defies graphs and statistics, as there is a large subjective element in medicine. After all, the practice of medicine is an art and a profession and not just a business. But since health care consumes more than 10 percent of the nation's GNP—requiring what economists call trade-offs from other sectors of the economy—it relies at its peril on the statement that the quality of its product is inherently immeasurable. So we are going to have to formulate minimum standards that will impress the gnomes in the Health Care Financing Administration (HCFA) not only that there are reliable measurements of quality, but that a quality product is the best and cheapest in the long run.

As Prof. William Hsiao of the Harvard School of Public Health says: when people are well they may focus on price competition; but when they are sick, they worry about quality rather than price. If these quality measures are not developed by physicians, they will be developed by non-physicians. Then I would worry about their

validity and about the concomitant loss of professional autonomy by physicians.

Even if the effort to block the deepest and most dangerous cuts in reimbursement is successful, as I believe it will be, the most we can hope for is that reimbursement will cover the expense of care of the covered patient, period. Hospitals, and particularly urban teaching hospitals, have historically used excess patient care revenues for three purposes—care of the indigent, teaching, and research.

It is conservatively estimated that there are now more than 37 million people nationwide not covered by any form of health insurance, a number that has been rising rapidly. Who will pay for their care? We have funds that yield about \$800 thousand a year that are devoted to this purpose. In 1986 we spent \$23 million on free care and bad debts.

Fortunately, one of the good features of the Massachusetts laws is that a free care pool is created by the insurers and Massachusetts employers. If it were not for that, we would be running a deficit that would soon make us bankrupt. Many states have no such provisions, and many states and hospitals simply don't take care of the poor.

We have never closed our doors to the indigent, and we are determined that we never will. But without help, we do not have and never will have the resources to take care of all who come to us. This is a problem that has to be addressed, and in the long term I can see no pocket big enough to provide the resources we need except that of the federal government. This will mean a very substantial increase in health care costs, and one has to worry about the willingness of Congress, whether Democratic or Republican, to take on such a heavy burden.

It becomes even more worrisome if Prof. Schwarz's article in the *New England Journal of Medicine* of Janu-

ary 9, 1987 turns out to be correct, and hospital costs skyrocket after 1990. Again I find myself far from full agreement with his position. Unquestionably, he is right in pointing out that the apparently inevitable growth in number of AIDS cases will have a severe effect on costs. Unquestionably, he is right also that over-use of new and expensive non-invasive diagnostic technologies may well occur. But I fail to see why the development and use of new technology will inevitably result in huge expenditure increases unless there is a "painful rationing."

There is another factor which is almost always ignored, partly because it is incredibly difficult to measure. It is that the successful application of new technology leads to cures which put people back into the work force where they contribute to the increase of the Gross National Product. To illustrate rising costs, Prof. Schwarz writes, "Because angioplasty is less traumatic than bypass surgery, it has opened the door to treatment of patients who are not candidates for surgery. As a result, the net savings from lowering the cost per procedure is likely to be offset by wider and more frequent application." But surely that application will result in removing disabilities and thus creating demonstrable economic benefits.

The ability to subsidize teaching and research out of the patient care budget will simply not exist in the future. New sources of funding will be necessary. Some of these new funds will be provided by various agencies of government, some of them will be provided by corporations and individuals. I am not too deeply discouraged by this prospect as I think that with diligent effort, funding will be found. Unfortunately for me, my term as chairman has coincided with the capital campaign at the MGH to rebuild our obsolete patient facilities. I say unfortunately because, as you all know, nothing is more boring or more difficult than raising money for bricks and mortar. But nothing is more important, either, and it simply has to be done.

Since this is my last report as chairman of your board of trustees, may I strike a personal note? I have been involved with a number of institutions, or to put it more accurately, with a number of groups of individuals. I have never met with any quite like the MGH group. We are not alone. In the long run a viable society will recognize and reward quality. □



# DR. WILLIAM

by Linda Covell Davis  
in collaboration with Lewis Carroll

"You are old, Dr. William," the intern said,  
"And your hair has become very white,  
Yet you made a house-call to a patient in bed;  
Do you think, in this age, that is right?"

"In my youth," Dr. William replied to his son,  
"We were taught to respond with compassion;  
If my patient's too sick to drive up to my door,  
I don't care if HealthStop is the fashion."

"You are old," said the youth, "and I hope that  
your Keough  
Will last till the end of your days;  
Tell me, why did you treat that poor woman  
for free?  
Won't you take what her Medicaid pays?"

"In my youth," said the doctor, "we treated  
the poor,  
Without charge in the big city wards;  
Now with third party payers, you see them  
no more,  
Without the financial rewards."

"You are old," said the intern, "and hospitalized  
That old chap with heart failure and flu,  
For three days, when, his DRG said,  
He was only entitled to two."

"When I was in training," the old doctor sighed,  
"I followed the handbooks that way, son;  
But depend less on science, and practice more art,  
For disease won't respect legislation."

"You're so old, Dr. William, you've lived in  
the days  
Before blots from all parts of the compass;  
Without ultrasound or probe DNAs,  
Pray, how did you make diagnosis?"

"Here is your envelope, son; you will find  
Category I credits within it;  
Do you think you can get CME without cost?  
Be off! Or I'll charge by the minute!"



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Linda Covell Davis '73 is a pathologist at Mt. Auburn Hospital.

# The Race for Credibility

by JudyAnn Bigby

# Faculty Perspective

*For the following piece, we asked two HMS faculty members to reflect on their experiences as minorities both before and after coming to the school. JudyAnn Bigby '78 is HMS instructor in medicine and associate physician at Brigham & Women's Hospital; Nancy Oriol is HMS instructor in anaesthesia and director of obstetric anaesthesia at Beth Israel Hospital. "The minority experience at Harvard—ranging from painful to gratifying—differs from the experience of the white majority," Bigby told the Bulletin, adding, "I feel it is important that our peers and colleagues recognize that the differences exist." Bigby held a Henry J. Kaiser Family Foundation Fellowship in General Medicine from 1981-83. Her two main research interests are quality assurance of outpatient medical care in large teaching hospitals, and the education of primary care and internal medicine residents in the diagnosis and treatment of substance abuse. Oriol has been director of obstetric anaesthesia at Beth Israel Hospital since 1985 and was assistant director for two years prior to that. She is particularly interested in high-risk obstetric anaesthesia and neonatal resuscitation. Oriol has served as BI's liaison to HMS for in-service continuing medical education, and on the school's Admissions Committee since 1983.*

"Nothing I shall ever accomplish will outweigh the fact of my race in the shaping of my destiny." This quotation from David Bradley in a 1982 issue of *Esquire* stands framed on a shelf in my office.

As a child, I decided to become a physician without really knowing what it would be like to practice medicine. My decision stemmed from wanting to help people, specifically minorities and the poor.

Growing up in a working-class family in a Black neighborhood, we did not go to a doctor unless we were acutely ill. There were no routine check-ups or ongoing relationships with primary care physicians. It was my impression that poor Black people generally could not afford the luxury of preventive medicine. They used the county hospital emergency room when necessary. The doctor's role was to save lives by treating serious, acute medical problems.

When my father developed hypertension during my adolescence I recognized that there was more to medicine than that. I also recognized my father's doubts about whether a white general practitioner would even accept him as a patient. That was when I decided to become a physician and practice in the Black community.

My subsequent medical education helped me realize, however, that opportunities for physicians are diverse and that minorities are underrepresented in all aspects of medicine. My current position at Brigham & Women's Hospital allows me to teach and do research, as well as take care of all types of patients, including minorities and the poor.

Interacting with minority students has been important to me. These students frequently tell me they feel an



obligation to return to their communities to practice medicine. But they also see opportunities in other aspects of medicine—research, health-care administration, public health—that also deserve a higher minority representation. They find it difficult, in the face of Harvard's emphasis on basic science and biomedical research, to know whether they really should aspire to become primary care physicians.

Helping students deal with these conflicts reinforces my impression that members of minority groups bring to the institution different and valuable backgrounds—important in helping us all learn to live and work in this pluralistic society. I am also aware that some believe consideration of race in selecting individuals for positions implies that minority candidates are not as well qualified as non-minority candidates and that minority candidates are accepted only if traditional standards are lowered.

As a Black woman physician at Harvard, I've had to face uncertainty about whether patients and colleagues will accept me as a capable physician. My secretary recently came into my office to offer some words of support after a white patient indicated, upon learning I was Black, that she was not going to stay for her appointment. I was able to convince my secretary that the incident was not important, but I'm not sure I really believe it wasn't.

It is hard for me to imagine that any patient would not allow a physician to prove herself capable and caring regardless of her color. I find it difficult not to take these experiences personally. On the other hand, I can't count the number of times elderly Black patients, upon being introduced to me, have openly expressed their pride and gratitude to have a Black physician take care of them. Even though these patients clearly feel that the color of their physicians can make a difference to them, I don't think any would find a white physician undesirable based on color alone.

The issue of how one is viewed by one's peers and colleagues is complex. Overly racist statements are infrequent, although they certainly do occur. A recent lecture at a Harvard-affiliated hospital included an analogy between the frequency of a rare side-effect of a commonly used medication and the chance of seeing a "nigger in a wood pile." The speaker may not have intended the remark to be racist, but it certainly demon-

strated an incredible lack of sensitivity toward the minority physicians in the audience.

More frequent are subtle and difficult-to-interpret statements. Finishing my fellowship and looking for a position in an academic setting, I was assured that I would have no difficulty finding a position because I was Black and a woman, and was therefore a "two-for-one." I couldn't help but wonder whether I would have had the same chances of being hired had I been a white male with comparable qualifications otherwise.

In spite of the complexities of being a minority physician in an institution which is, and has traditionally been, dominated by white males, my experience has been overwhelmingly



*Students at HMS*

positive. The opportunities to work with bright, thoughtful, creative individuals have been stimulating and encouraging. My patients are a continual source of gratification.

The experiences of minorities within this academic medical institution reflect the ongoing difficulties of minorities in American society in general. Once I leave the hospital, my white coat, and my name tag behind, I am subject to the same treatment as any other Black resident of the Boston area.

Nothing could have emphasized this truism more than a recent experience on a street in Brookline, less than a block away from my home. An elderly white gentleman approached me and asked if I was interested in any cleaning jobs. I said no, but I could get him a good doctor if he was interested in that. □

# Taking Care of the Ladies

by Nancy Oriol

*Supported by my father's expectations and my mother's hopes, I knew I could be anything I wanted, and I wanted to be a doctor even though I was a girl, and a colored girl at that.*

Black comes in many colors, from light khaki to ebony. I am one of those light khaki Blacks with blondish hair and green eyes—a bit of a shock to the West Indian half of my family. Growing up in the 1950s, my multi-colored family and I fit right into the rainbow of colors in Philadelphia's Black bourgeoisie.

I entered adolescence in the '60s, and my whole generation decided to change the status quo. In the turmoil, my fanciful grandmother from the Afro-American half of my family suggested I go to Boston. "In the old days back home in Virginia," she said, "plenty of girls who looked like you were sent to school in Boston to learn to take care of ladies." My generation did make a difference and, strangest of all, I did go to school in Boston and learn how to take care of ladies. In fact, I went to Harvard Medical School and am now director of obstetric anaesthesia at Beth Israel Hospital. I wonder if that's what Grammy Singleton had in mind.

How did someone like me get to a place like this? The West Indian work ethic is one that even Horatio Alger would be proud of. Supported by my father's expectations and my mother's hopes, I knew I could be anything I wanted, and I wanted to be a doctor even though I was a girl, and a colored girl at that. I had role models of whom I had heard but never met; the important thing was that they had paved the way. In high school, one committed medical educator from the majority establishment (Victor P. Satinsky, M.D.) helped me, and other inner-city teenagers, see where we could fit into the medical world.

For both financial expediency and emotional well-being, I took an eight year side-step away from school into

teaching and child rearing. I returned to my dream of medicine later only to find that I shared that dream with 42,000 other pre-meds. Driven by the memory of my parents and guided by insights gained over the previous eight years, I stormed through pre-med and gained admission to HMS in 1979.

If you're not part of the solution, the aphorism states, you're part of the problem. HMS is committed to being part of the solution and, by all accounts, it's succeeding. There are many qualified applicants for every medical school position. Affirmative action does not mean letting unqualified minorities in, it means letting qualified minorities in, acknowledging that they are of a different race. Harvard could easily fill its ranks with



Nancy Oriol today

its own, but it chooses to admit interesting applicants from diverse backgrounds. My class had writers, potters, ministers, Appalachian poor, Wall Street rich, 27 minorities, and 139 other interesting students. It was this diversity that brought color to Fair Harvard and helped make the Harvard experience unique.

In the enlightened society of HMS, blatant racial slurs are rare. When they do occur, they tend to damage the speaker more than the listener. Quiet damage is done to minority students, however, by the more subtle 'rumors of inferiority', which Jeff Howard and Ray Hammond first spoke of in 1985 ("Rumors of Inferiority," *The New Republic*, September 9, 1985). Rumors of this kind



state that minority students only get into schools like HMS to fill minority quotas, and that they are not really as qualified as others.

Most HMS students, except the truly great or truly deluded, think they got in "through the back door." We all suspect it is only a matter of time before *they* figure out they made a mistake. Insecurity pervades. Rumors of inferiority, together with normal fear of inadequacy, confirm even the worst fears of a minority student and could undermine their entire educational experience.

Medical school was a great experience. It was much more rewarding to me than any job I had ever held. Banks even lent me money for support while I did something as gratifying as study science. I had made it to the top of the pre-med heap. This was the lap of intellectual luxury.

As with anything else, there were some awkward moments. Being Black, and looking white to some, I had to explain to Caucasian acquaintances that Black didn't always mean black. This was all the more embarrassing if that person had just made some ethnic or racial slur.

There were also humorous times. One interviewer of my own ethnic persuasion once painfully beat around the bush trying to figure out if I was also a person of color. Under the Harvard mandate not to ask racially or sexually biasing questions, he could not ask me straight out.

Students grow by attempting to live up to the high expectations of people they respect. I was lucky during medical school to have several mentors (of all colors and both sexes) who challenged me with their confidence and helped make me strong. Now, I counsel medical students as part of the growing Black old-girl network. I am grateful for these opportunities to work with students and share with them the strength my mentors gave to me.

After medical school, I went on to train in surgery and then anaesthesia at Boston's BIH. I found the environment at BIH honest and supportive, and I have remained here as a staff anaesthesiologist.

As an anaesthesiologist, I interact with patients in very intense situations. Patients demand that the person they hand control of their lives to, be someone they can trust. Their lasting impression is not the color of your skin but how you treat them during their vulnerable moment of dependency.

Part of my job as director of obstetric anaesthesia is to follow up on patient complaints. So far, I have never heard a patient complain about their care because of their physician's ethnic background. I did, however, once hear a complaint from a highly-educated minority patient who perceived a put-down when her non-minority physician used elementary school monosyllables to explain a procedure. And I had an interesting experience during a recent emergency call. I did not have time to review the chart of one woman before I was deeply involved in her care. Everything turned out well, and the



patient and her family were effusively grateful.

*Oriol with father in 1952*

I later found a nurse's note in her chart, stating that this patient had a phobia of Black people and did not want minority physicians involved in her care. Ironically, this same patient told me that she had heard about me (obviously not everything) and had intended to explicitly request me as her anaesthesiologist. I never got a chance to discuss this with her, but it might not have helped. I felt sorry for this woman. Little did she know that, but for a quirk in a mitotic cell division 40 years ago, she would not have accepted care from me at all. □



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